THE NATIONAL TRIBAL BEHAVIORAL HEALTH AGENDA

DECEMBER 2016

The development of a TRIBAL BEHAVIORAL HEALTH AGENDA is long overdue. And the development of this particular document and its contents was the result of months of discussing, analyzing, validating, sharing, and revalidating. The Tribal Behavioral Health Agenda was a collaborative effort between many Tribes, leaders, organizations, and federal agencies.

The authors would like to acknowledge that the idea for this document originated from direct discussions with Tribal leaders around the challenges Tribes are facing with behavioral health.

It was their *passion vision* AND *dedication* that led to the development of this Agenda.

FEDERAL LEADERSHIP LETTER

DEAR TRIBAL LEADERS, FEDERAL PARTNERS, AND OTHER COLLABORATORS:

There has never been a more important time to work together to improve the behavioral health – mental and substance use disorders – of American Indians and Alaska Natives. Mental and substance use disorders are impacting tribal communities and, in many cases, rates for specific disorders are higher when compared to other communities in the United States. The relationship between behavioral health, overall health, and well-being is unequivocal. Behavioral health is influenced by factors that also influence overall health, and people with mental and substance use disorders may have higher rates of physical health problems.

The Substance Abuse and Mental Health Services Administration (SAMHSA) and the Indian Health Service (IHS) are committed to collaborating with tribal nations, urban Indian health programs, other federal departments and agencies, and other entities to improve the well-being of American Indians and Alaska Natives. SAMHSA, as the lead federal agency for advancing the behavioral health of the nation, is working to reduce the impact of mental and substance use disorders on America's communities, including tribal communities.

IHS, in partnership with tribal health and urban Indian health programs, is working to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level. Through complementary missions, federal, tribal, urban Indian health, and other entities can work together to improve behavioral health and overall wellness.

The concept for the National Tribal Behavioral Health Agenda (TBHA) was born from the voices of tribal leaders who spoke compellingly about the extent to which mental and substance use disorders are impacting tribal communities. Beyond the issues, they also spoke about the need for collaboration and working differently together in order to make a difference in the lives of American Indians and Alaska Natives. SAMHSA and IHS accepted the advice and worked with the National Indian Health Board to gather input on what would ultimately become the TBHA.

Through discussions, five elements which form the foundation for the TBHA were developed and affirmed by tribal leaders and tribal representatives. Through many more discussions, content of what would become the priorities and strategies for the TBHA emerged and were affirmed. Thus, the TBHA includes foundational elements, priorities, and strategies that chart a course for more meaningful collaborations and opportunities for strengthening policies, programs, and activities.

The content and order of the information in the TBHA hold significance. Globally, there are three significant components to this document. These components include the American Indian and Alaska Native Cultural Wisdom Declaration (CWD); sections which provide background and form *Part One* of the document; and, sections which comprise the substance of the TBHA and are included in *Part Two* of the document.

The CWD was developed by tribal leaders and representatives who sought to elevate the importance of tribal identities, culture, spiritual beliefs, and practices for improving well-being. The intent of the CWD is to ensure that cultural wisdom and traditional practices are taken into account and supported as fundamental elements of programs, policies, and activities that are designed, or contribute, to improvements in behavioral health.

Part One of the document provides background on the historical and current contexts of tribal communities, data on targeted behavioral health issues faced by American Indians and Alaska Natives, and health care service system issues and considerations. The TBHA is a collaborative tool – it can be used by any entity that has the ability to contribute positively to tribal communities. As such, the information aims to achieve common understanding of the issues requiring collaboration.

Part Two of the document includes the foundational elements, priorities, and strategies of the TBHA that were derived through tribal input. The components of the TBHA are not all-inclusive but rather, collectively they reflect areas of agreement across many conversations that have been elevated for collaboration. *Part Two* also includes examples of current federal programs that are synergistic with the foundational elements, priorities, and strategies. The federal examples underscore that critical programs exist and can be effectively leveraged to improve behavioral health.

SAMHSA and IHS commit to working with you to advance the TBHA, improve behavioral health, and contribute to the well-being of American Indians and Alaska Native people.

Kana Enomoto
Principal Deputy Administrator
SAMHSA

Mary Smith
Principal Deputy Director
IHS

AMERICAN INDIAN AND ALASKA NATIVE CULTURAL WISDOM DECLARATION

This statement is an attempt to motivate and set in motion, culturally derived efforts that will address the present state of health for American Indian and Alaska Native people. American Indian and Alaska Native tribes are diverse and unique in culture and traditions but share a common history in our relationship with the Federal government and common goals for improving the lives of our people. We hope this statement will be accepted and supported by American Indian and Alaska Native tribes as a statement of intent that will move us forward in preserving and promoting our identities and cultural and spiritual beliefs and practices while practicing our respective traditional wisdom in health protection that has been passed from generation to generation.

As indigenous people, we possess the culturally relevant knowledge and expertise to address and enhance the overall health and well-being of all American Indian and Alaska Native people across the country. We also expect this statement will be honored and implemented by U.S. Federal Agencies, state agencies, and private and non-profit organizations charged with improving the health status of American Indian and Alaska Native people.

BACKGROUND

Native Americans are experiencing vast health inequities as evidenced by high rates of cancer, diabetes, trauma, mental and substance use disorders (including suicide), and unintentional injury. Present efforts to address the health status of American Indian and Alaska Native- people remain marginally effective in alleviating these health disparities. While research and programs consistently recommend that prevention and health care programs also implement traditional practices and philosophies, barriers exist that prevent the successful implementation of culturally tailored health promotion and healing interventions.

The intent of this declaration is to address the existing barriers and move towards successful implementation of culturally driven health promotion models of care and healing. This declaration promotes the voice of American Indians and Alaska Natives to ensure success in embedding culturally relevant health promotion and healing interventions into health and human service initiatives supported by Tribes, Federal agencies, and other entities.

WE BELIEVE...

We honor the ancestral cultural knowledge, wisdom, ceremony, and practices of American Indian and Alaska Native tribes. Our respective cultural knowledge is sacred and has been practiced for centuries as evident in our shared inter-tribal survival and resilience. This traditional cultural wisdom predates the U.S. Constitution. We are experts of our own cultural wisdom. Our wisdom has been passed down orally from generation to generation, and the depths of our wisdom remains within the hearts and minds of our people. Our cultural wisdom exists solely for us. It is tribe specific and this sacred knowledge exists to benefit our health, our well-being, and the health and well-being of future generations. Our cultural wisdom is guarded and protected

because of the history of broken promises and broken trust we have experienced over and over again. Our cultural wisdom will remain protected. Our cultural wisdom will continue to be transferred orally, as it has been in the past. Our worldview on health and healing is holistic, encompassing the body, mind, spirit, nature and our environment.

WE WILL....

We will preserve and implement our cultural wisdom as a means to promote health and well-being in our communities through stories, songs, prayers, rituals, and ceremonies and other traditional practices. Our respective traditional wisdom, ceremonies, language, and customs will be implemented in our communities to benefit our present and future generations while we honor the ancestral and sacred elements of this knowledge and control its use and dissemination. All details of cultural wisdom will remain authentic to traditional ways of being, knowing, and doing. We will integrate authentic cultural interventions alongside existing healthcare promotion efforts to ensure a culturally tailored and culturally relevant approach to health promotion and healthcare delivery for American Indian and Alaska Native people.

WE KNOW....

We know that Native American wisdom exists within our stories, language, ceremonies, songs, and teachings. We know our Native ways are effective. We know that these ways are different from the Western worldview. We know we are experts in practicing and implementing our traditional ways to enhance the health of our people. We know our ways are unique and specific to Tribal groups. The authenticity of our Native American cultural wisdom is acknowledged and validated by our families, our clans, our communities. This knowledge has been validated for centuries by our ancestors. This knowledge exists within American Indian and Alaska Native communities, it is known by our people, and we will protect this sacred knowledge.

We expect the following from those agencies that have power, authority and funding relevant to American Indian and Alaska Native health including Tribal, State, Federal, private and non-profit organizations:

- TRUST
- RESPECT
- ACCEPTANCE
- COMMITMENT
- SUPPORT
- FINANCIAL RESOURCES

And to ensure the success of this declaration we recommend the following:

- Respect our intent to keep sacred knowledge private and allow details of this cultural knowledge and wisdom to remain with the knowledge keepers (elders, traditional healers, storytellers, and American Indian and Alaska Native people).
- Support our unique ideas and models of health and healing interventions that may not fit typical or standard western approaches.
- Modify your requirements to fit the relevant traditional tribal paradigm or allow room for flexibility when evaluating proposals submitted by American Indian and Alaska Native tribal nations.
- Provide adequate time and financial resources required to work in rural and remote areas, with hard to reach populations and within the legal frameworks of sovereign nations.
- Trust the Nations to deliver their culturally derived interventions.
- Accept our distinct American Indian and Alaska Native cultural ways of being, knowing and doing.
- Support our authority to practice American Indian and Alaska Native culture as practiced for generations, without modification, without restriction.
- Support the cost of structuring innovative and culturally tailored models of health promotion through advocating for additional funding in the form of budget increases and specific grant funding that targets unique American Indian and Alaska Native health promotion efforts.

The following individuals, Tribes/Nations and Other American Indian and Alaska Native community agencies and organizations support this statement.

SIGNATORIES

Lincoln Bean – Chairman, Alaska Native Health Board

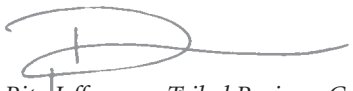
Vernon Miller – Chairman, Omaha Tribe of Nebraska

Aaron Payment – Chairman, Sault Ste. Marie Tribe of Chippewa Indians

Andy Joseph, Jr. – Tribal Council Member, Confederated Tribes of the Colville Reservation

Tina Richards – Tribal Business Council Member, Susanville Indian Rancheria

Wilfrid Cleveland – President, Ho-Chunk Nation



Rita Jefferson – Tribal Business Council Member, Lummi Nation

Tom Johnson, Jr. – Chairman, Sun'aq Tribe of Kodiak

Marilyn M. Scott – Tribal Council Member, Upper Skagit Indian Tribe

Patsy M. Bain – Tribal Council Member, Makah Tribe

Lester Secatero – Chairman, Albuquerque Area Indian Health Board

Patrick Marcellais – Tribal Council Representative, Turtle Mountain Band of Chippewa Indians

Vinton Hawley – Chairman, Pyramid Lake Paiute Tribe

Lisa Elgin – Tribal Administrator, Manchester-Point Area Band of Pomo Indians

Chester Antone – Tribal Legislative Council Member, Tohono O'odham Nation

Marty Wafford – Chairperson, Southern Plains Tribal Health Board

Thomas Beauty – Chairman, Yavapai-Apache Nation

ACKNOWLEDGMENTS

The development of the first National Tribal Behavioral Health Agenda (TBHA) is long overdue. The concept for the TBHA came from the Substance Abuse and Mental Health Services Administration's (SAMHSA) Tribal Technical Advisory Committee (TTAC) and was driven forward by the HHS Secretary's Tribal Advisory Committee.

SAMHSA owes a debt of gratitude to Joe Garcia (Ohkay Owingeh Pueblo) whose vision initiated the TTAC discussion and who passionately spoke about the importance of Tribal leaders' voices in framing a behavioral health agenda for Tribal nations. SAMHSA also appreciates the leadership and guidance from other Tribal leaders on the TTAC whose collective voices helped shape and guide completion of the TBHA: Timothy Ballew II (Lummi Indian Nation), Brooks Big John (Lac du Flambeau Tribe), Amber Crotty (Navajo Nation), Anthony J. Francisco, Jr. (Tohono O'odham Nation), Andy Joseph, Jr. (Confederated Tribes of the Colville Reservation), Juana Majel-Dixon (Pauma Band of Luiseno Mission Indians), Keith Massaway (Sault Ste. Marie Tribe of Chippewa Indians), and Vernon Miller (Omaha Tribe of Nebraska).

The insight and guidance provided by the U.S. Department of Health and Human Services Secretary's Tribal Advisory Committee (STAC) during many discussions about behavioral health and in particular, suicide in Indian Country, were invaluable in shaping the TBHA. In addition, the input and support from Tribal leaders on the Board of Directors for the National Indian Health Board were significant and appreciated.

Special appreciation is extended to Cathy Abramson (Sault Ste. Marie Tribe of Chippewa Indians) and Chester Antone (Tohono O'odham Nation) whose dedication to uplifting the behavioral health of American Indians and Alaska Natives and their engagement on the TBHA throughout its development have proven them to be champions for Native people.

The process for developing the TBHA was the result of months of information-gathering and discussing, analyzing, validating, sharing, and revalidating the input received. SAMHSA's Office of Tribal Affairs and Policy (OTAP) worked with the Indian Health Service's (IHS) Office of Clinical and Preventive Services (OCPS) and the National Indian Health Board (NIHB) to engage Tribal leaders, Tribal administrators, and Tribal members to obtain input and ensure that Tribal voices were honored in developing the TBHA. The following individuals are recognized for their leadership in bringing Tribal leaders' vision for the TBHA to fruition:

- **MIRTHA BEADLE**, OTAP, SAMHSA
- **STACY BOHLEN** (Sault Ste. Marie Tribe of Chippewa Indians), NIHB
- **SHEILA COOPER** (Seneca Nation), OTAP, SAMHSA
- **BEVERLY COTTON** (Mississippi Band of Choctaw Indians), Division of Behavioral Health (DBH), OCPS, IHS

- **JACQUELYNN ENGEBRETSON** (Ahtna Athabascan), NIHB
- **ROBERT FOLEY**, NIHB
- **HANKIE ORTIZ**, Bureau of Indian Affairs
- **MARCELLA RONYAK** (Confederated Tribes of the Colville Reservation), DBH, OCPS, IHS
- **DEBORAH SCOTT** (Cherokee Nation), Sage Associates, Inc.
- **ALEC THUNDERCLOUD** (Ho-Chunk Nation), OCPS, IHS

An essential component of the TBHA is the American Indian and Alaska Native Cultural Wisdom Declaration which promotes inclusion of culturally relevant health promotion and healing interventions in all health and human services. The authors of the Declaration are recognized for their invaluable contribution toward reducing barriers to culturally driven care and healing:

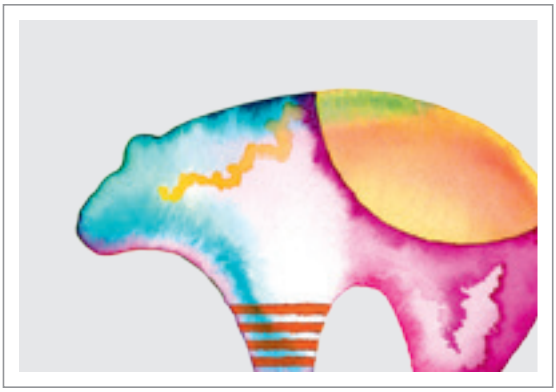
- **CHESTER ANTONE** (Tohono O'odham), STAC Chair
- **MIGUEL FLORES** (Tohono O'odham/ Pascua Yaqui), IHS Phoenix Area
- **MICHELLE KAHN-JOHN** (Navajo), College of Nursing, University of Arizona
- **TESHIA ARAMBULA SOLOMON** (Choctaw/ Mexican/American), Native American Research and Training Center, University of Arizona

Appreciation is extended to the following individuals for providing technical expertise and support for the TBHA: Tom Anderson (Cherokee Nation), Oklahoma Area Tribal Epidemiology Center; Frank Bajowski, Cabezon Group, Inc.; Carla Britton, Alaska Native Epidemiology Center; Dawn Coley (Penobscot Nation), NIHB; Devin Delrow (Navajo Nation), NIHB; Kristin Hill, Great Lakes Inter-Tribal Epidemiology Center; Michael Koscinski, OIASA, OTAP, SAMHSA; Byron Larson (Northern Cheyenne Tribe), Urban Indian Health Institute; Caitrin Shuy, NIHB; Donna Cay Tharpe, Cabezon Group, Inc.; and the Tribal Law and Order Act Indian Alcohol and Substance Abuse Coordinating Committee's Data Workgroup.

The TBHA was a collaborative effort among tribes, Tribal leaders, national and regional Tribal organizations, SAMHSA Regional Administrators, SAMHSA staff members, and Federal partners. Three specific Tribal organizations – National Indian Health Board, National Council of Urban Indian Health, and National Congress of American Indians – were instrumental in supporting, advancing, and disseminating the TBHA. Although it is difficult to identify all supporters by name, the TBHA would not have been possible without all of you.

TRIBAL BEHAVIORAL HEALTH AGENDA

CONTENTS



Part Two

EXECUTIVE SUMMARY

THE VOICES

Suicide pacts among American Indian youth in small and tight-knit communities

Long waiting lists to see a health provider

Providers who have little understanding of historical and traditional practices

These comments are but a few of the concerns voiced by hundreds of Tribal members when asked about behavioral health issues in their communities. The story of American Indians and Alaska Natives is one of resiliency and survival. However, threats such as social injustices, perpetuated over multiple generations, continue to have enduring consequences for Tribal communities and contribute to the behavioral health problems being experienced today.

The problems – which result from adverse childhood experiences and traumatic events experienced historically and intergenerationally – are reflected in high rates of interpersonal violence, depressive symptoms (depression and unresolved grief and loss), substance use (drug misuse use as well as illicit drug use), and suicide. The root causes and resulting behavioral health issues impact other areas that contribute to well-being such as overall health, education, employment, child welfare, and engagement with the justice system that create an urgent need for Tribes, Federal agencies, and other interested parties to work together differently and more effectively.

The idea for a comprehensive document focused on the behavioral health of Tribal communities was brought forward by concerned and engaged Tribal leaders. There is no one single national program or document that brings together and elevates the importance of behavioral health for Native people, identifies priorities developed by Tribal communities, and guides incorporation of strategies to improve the well-being of youth, families, and communities. Many individuals and organizations play a role in addressing behavioral health and their related problems and are at times loosely connected through a broad landscape of Tribal and Federal projects, programs,

initiatives, and funding streams that require better coordination to improve well-being.

To bring the TBHA idea to fruition, the Substance Abuse and Mental Health Services Administration, Indian Health Service, and the National Indian Health Board shared information and facilitated discussions and meetings with hundreds of Tribal leaders, Tribal administrators, Tribal members, advocates for American Indian and Alaska Native health, Native youth, and Federal agency representatives. From the many meetings and discussions emerged a series of overlapping opportunities and priorities that serve as the framework for the National Tribal Behavioral Health Agenda (TBHA). The TBHA is not a strategic plan; rather it is a guiding blueprint that will assist in strengthening policies and programs, aligning disparate resources, and facilitating collaboration. It identifies existing strategic plans and efforts that can serve as initial pathways for action and a single, unifying tool around which engaged parties can gather, utilizing common language and priorities. All parties have a responsibility and role to play in creating solutions that are viable and sustainable, and the TBHA provides the needed framework and priorities for doing so.

The TBHA framework is organized around five foundational elements that provide both content and direction. The foundational elements were dominant themes from early formative work with Tribal leaders and capture the opportunities and issues presented. Underlying each of the five foundational elements are priority areas that reflect the recurring issues raised by Tribal leaders, Tribal members, and stakeholders as outlined on the following page.

Within the priority areas are strategies that can be framed to address unique community circumstances. The strategies are not prescriptive and range from engaging key stakeholders in policy and systems changes to examining

staffing patterns to create a healthier and more responsive workforce. Some strategies are appropriate for Tribal governments, whereas others are more appropriate for Federal partners or even individual community members, reflecting opportunities where interested parties can engage.

Tribal leaders, Tribal council members, Tribal administrators, American Indian and Alaska Native health advocates, and Federal agency representatives have consistently called for coordination and collaboration among the distinct jurisdictions and entities whose efforts contribute to the health and well-being of American Indian and Alaska Native communities. The TBHA offers the opportunity for these parties to find common ground for developing interrelated and integrated actions for addressing the behavioral health needs of American Indians and Alaska Natives. This includes a commitment to incorporate the long-held wisdom and cultural practices of Tribal communities and Western approaches and systems in identifying solutions, garnering appropriate attention and resources for addressing outstanding challenges, and mobilizing collaborators to act together to combat localized behavioral health and related issues. The TBHA creates a platform that will allow Tribal and Federal collaborators to chart priorities for funding, programs, and policy decisions. Collaboration is the power of the TBHA.

THE TRIBAL BEHAVIORAL HEALTH AGENDA FOUNDATIONAL ELEMENTS

1. HISTORICAL AND INTERGENERATIONAL TRAUMA

- SUPPORT SYSTEMS
- COMMUNITY CONNECTEDNESS
- BREAKING THE CYCLE

2. SOCIO-CULTURAL-ECOLOGICAL APPROACH

- SUSTAINING ENVIRONMENTAL RESOURCES
- RELIABLE INFRASTRUCTURE
- HEALTHY FAMILIES AND KINSHIP

3. PREVENTION AND RECOVERY SUPPORT

- PROGRAMMING THAT MEETS COMMMUNITY NEEDS
- COMMUNITY MOBILIZATION AND ENGAGEMENT

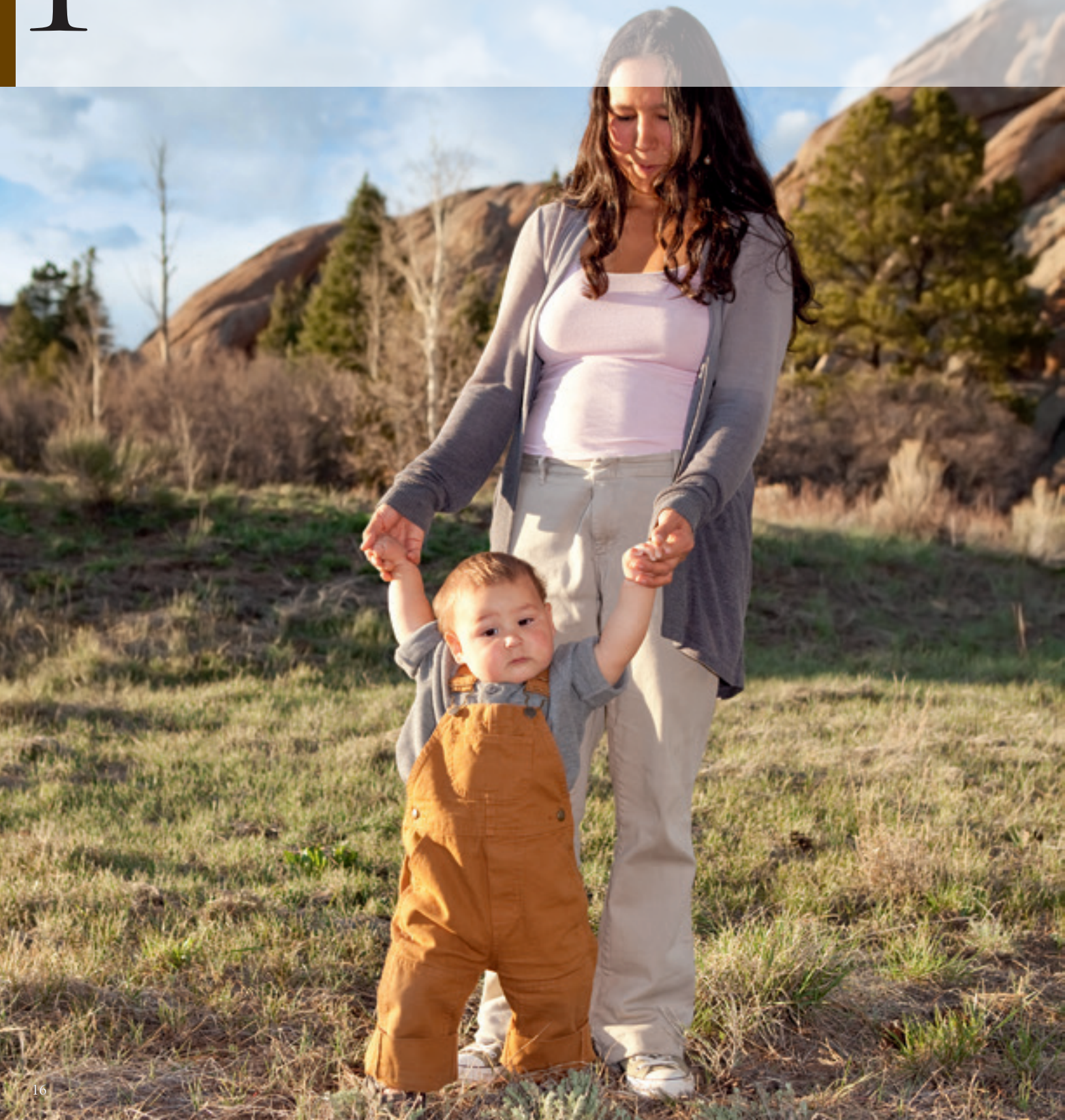
4. BEHAVIORAL HEALTH SYSTEMS AND SUPPORT

- WORKFORCE DEVELOPMENT
- FUNDING MECHANISMS
- TRIBALLY DIRECTED PROGRAMS
- YOUTH-BASED PROGRAMMING
- SCOPE OF PROGRAMMING
- LAW ENFORCEMENT AND JUSTICE PROGRAMS

5. NATIONAL AWARENESS AND VISIBILITY

- TRIBAL CAPACITY BUILDING
- TRIBALLY DIRECTED COMMUNICATION STRATEGIES
- COLLABORATOR CAPACITY BUILDING

1 INTRODUCTION



The significant health issues confronting American Indian and Alaska Native communities on a national scale are well known and well documented. What is not as well documented are the stories of success and survival that often accompany daunting health and behavioral health concerns. The term "behavioral health" refers to the promotion of mental health, resilience, and well-being; the prevention and treatment of mental and substance use disorders; and the support of those who are in recovery from these conditions, along with their families and communities.[1] Strength and resiliency are ingrained traits of American Indian and Alaska Native communities. Adaptability has become an equally important attribute as contemporary times and challenges have forced these communities to examine their health and wellness through the predominantly Western lenses of clinical care, programmatic effectiveness, sustainability, and impact.

Tribal leaders have voiced concerns about the state of behavioral health in Indian Country. Tragic stories have been shared of continuing suicides among youth in small, tight-knit communities. Stories have been shared of long waiting lists to see a behavioral health provider who is only in the community a limited number of days a month. Other stories have been shared of providers who are not knowledgeable enough of local traditions to work with their clients in a manner that honors historical and traditional practices. These stories paved the path to where we are today. Now is the time to inventory the collective knowledge, resources, and commitment for addressing behavioral health issues and converting opportunities to action.

The National Tribal Behavioral Health Agenda (TBHA) honors the history and trust relationship that the U.S. Government has with American Indian and Alaska Native tribes by acknowledging barriers, identifying common priorities, and proposing strategies that can be addressed by Tribes, Federal agencies, and other entities working together. All parties have the goal of improving the well-being of American Indians and Alaska Natives, and the TBHA was created as a blueprint for informing programs, policies, and activities that can assist in reaching that goal.

PURPOSE OF THE NATIONAL TRIBAL BEHAVIORAL HEALTH AGENDA

Tribal leaders, Tribal administrators, American Indian and Alaska Native health advocates, and Federal agency representatives have consistently called for coordination and collaboration among the distinct jurisdictions and entities whose efforts contribute to the health and well-being of American Indian and Alaska Native communities. One view is that the many programs and initiatives intended to improve the spiritual, physical, and emotional health of American Indians and Alaska Natives operate in isolation and would be more effective if they worked more closely together. Underpinning this view are the following tenets:

- American Indians and Alaska Natives continue to face significant behavioral health problems, and the factors that serve as determinants of these health challenges vary greatly.
- Behavioral health issues are not isolated. Behavioral health shares important correlations with physical health as well as with social and economic conditions in Tribal communities that require a more collective and collaborative approach. These correlations require a broader view of the components of a comprehensive prevention and treatment approach to behavioral health issues.

- The high rates of behavioral health problems among American Indians and Alaska Natives create urgency for Tribes, Federal agencies, and other entities to work together in a manner that meaningfully improves the well-being of Tribal communities.

- The Federal Government has a trust responsibility for improving the health and well-being of American Indians and Alaska Natives.

- There is no single national program or document that elevates the importance of behavioral health for American Indians and Alaska Natives, identifies the collective priorities of Tribal communities related to behavioral health, and guides the development and/or incorporation of behavioral health-related actions to improve the well-being of American Indian and Alaska Native youth, families, and communities.

The TBHA is not a strategic plan. It is not intended to replace existing strategic plans or prescribe a set of actions that Tribal, Federal, state, and local governments or other stakeholders should take to address the behavioral health of American Indians and Alaska Natives. Rather, the TBHA is a blueprint that:

- Provides a clear national statement about the extent and need to prioritize behavioral health and related problems, their impact on the well-being of Tribal communities, and a set of strategies based on direct input from Tribal leaders and representatives.

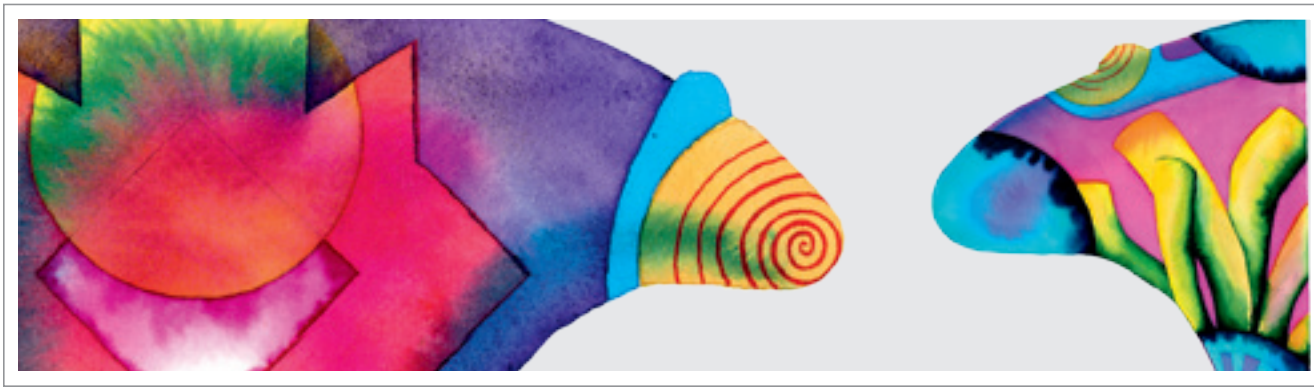
- Identifies foundational elements that should be considered and integrated into both existing and potential programmatic and policy efforts.

- Elevates priorities for action that could or are likely to contribute to meaningful progress in tackling persistent behavioral health problems for Native youth, families, and communities.

- Creates a platform to allow Tribal and Federal collaborators to routinely examine funding, program, and policy priorities that best support opportunities to improve communication, align efforts, and make real and measurable improvements in behavioral health for American Indians and Alaska Natives.

DEVELOPMENT OF THE NATIONAL TRIBAL BEHAVIORAL HEALTH AGENDA

The idea and necessity for a blueprint such as the TBHA were brought forward by the Tribal Technical Advisory Committee of the Substance Abuse and Mental Health Services Administration (SAMHSA), which comprises elected Tribal leaders. The concept was advanced by other equally concerned and engaged Tribal leaders who also witnessed inequities in resources available to non-Native communities, compared with Native communities experiencing significant challenges, such as multiple suicides. In response, SAMHSA and the Indian Health Service (IHS) worked to lay the foundation for what would become the TBHA. To bring this idea to fruition, SAMHSA, IHS, and the National Indian Health Board (NIHB) engaged in discussions with Tribal leaders and members, Tribal administrators, Tribal advocates for American Indian and Alaska Native health, and Federal agency representatives over an 18-month period through the end of 2015.



Input was received through facilitated sessions held independently or that took place during other scheduled Tribal and Federal gatherings and meetings (see Appendix 1. Highlights of Key National Tribal Behavioral Health Agenda Information-Gathering Sessions). Dedicated conference calls with elected Tribal leaders also took place concerning efforts to develop the TBHA. Because it was important to garner Federal input in the process, the U.S. Department of Health and Human Services (HHS) hosted a Federal interagency forum in December 2015 to discuss current Federal programming that might align with the TBHA. Federal interagency forum discussions demonstrated a synergy between Tribal and Federal representatives that substantial opportunity exists for greater collaboration. Participants at the forum included representatives from the following agencies:

- Administration for Children and Families (ACF), HHS
- Administration for Community Living (ACL), HHS
- Bureau of Indian Affairs (BIA), U.S. Department of the Interior
- Centers for Disease Control and Prevention (CDC), HHS
- Centers for Medicare & Medicaid Services (CMS), HHS
- Health Resources and Services Administration (HRSA), HHS
- IHS, HHS
- National Institutes of Health (NIH), HHS
- Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice (DOJ)
- SAMHSA, HHS
- Social Security Administration (SSA)
- U.S. Department of Veterans Affairs (VA)

Collectively, the input sessions allowed participants to share information on behavioral health and related priorities, the nature of behavioral health service delivery, significant successes and challenges, and considerations for advancing behavioral health among American Indian and Alaska Native people and communities. A qualitative strategy for analyzing the input received, in a manner that honored all of the feedback and input, was adopted. The development process was inherently iterative, with prior meetings and discussions shaping subsequent conversations to validate and supplement previous information and conclusions. Discussions were transcribed and then analyzed manually in teams of two or three people to examine similarities and identify broader themes. At the end of the process, data were categorized and collapsed into foundational elements and recommendations across all conversations. Across discussions, Tribal leaders and representatives agreed to the importance of a TBHA, the foundational elements, and considerations for the development of the TBHA.

2 HISTORICAL AND CURRENT CONTEXTS

Story of Survival

Each Tribal nation across the United States has a unique history, culture, language, and story, contradicting the generic and ethnic sameness that might be implied by the terms "American Indians" and "Alaska Natives."

FEDERALLY RECOGNIZED TRIBAL GOVERNMENTS

The United States has a unique government-to-government relationship with Indian tribes that is grounded in the U.S. Constitution, numerous treaties, statutes, Federal case law, regulations, and executive orders that establish and define a trust relationship with Indian tribes.

GEOGRAPHY

Within the boundaries of the United States, there are currently 567 federally recognized and dependent sovereign American Indian and Alaska Native nations, tribes, rancherias, villages, and pueblos and 65 state-recognized tribes.[2] Federally recognized tribes with reservation lands are on one of 326 federally recognized American Indian reservations.[3] Through allotment policies established in the 19th century, many tribes lost communally held lands, with ownership passing out of Tribal jurisdiction. Tribal members continued to congregate in established communities, and today they account for tribes with no federally recognized reservations, such as the 39 tribes in Oklahoma.[4]

Through other policies focused on relocating or "terminating" tribes in the 1950s, American Indian and Alaska Natives from many tribes were moved to 12 urban areas to better access employment and to encourage assimilation.[5] Today, these urban areas are home to the larger urban American Indian and Alaska Native groups, with most living in small, scattered pockets across vast cityscapes.

POPULATION

American Indians and Alaska Natives total more than 6.6 million persons or 2% of the total U.S. population, with 48% identifying as solely one race and 52% identifying as American Indian and Alaska Native and at least one other race.[6] The majority of American Indians and Alaska Natives, about 71%, live in rural, urban, or suburban areas rather than on reservations.[7,8]

There are 21 states with 100,000 or more American Indian or Alaska Native residents – California, Oklahoma, Arizona, Texas, New York, New Mexico, Washington, North Carolina, Florida, Michigan, Alaska, Oregon, Colorado, Pennsylvania, and Minnesota.[9] The following 10 cities are home to the largest number of urban American Indian and Alaska Natives: New York City, Los Angeles, Phoenix, Oklahoma City, Anchorage, Tulsa, Albuquerque, Chicago, Houston, and San Antonio.[10]

AGE AND EDUCATION

American Indian and Alaska Native populations are overall younger than the general U.S. population. In 2014 the mean age of American Indians and Alaska Natives was 31.4 years compared with 37.7 years for the U.S. population at large.[11] American Indians and Alaska Natives also tend to be less well educated. The dropout rate for Native students is twice the national average, the highest of any U.S. ethnic or racial group. About 3 out of every 10 American Indian and Alaska Native students drop out before graduating from high school, both on reservations and in cities.[12]

UNEMPLOYMENT

Accurate estimates of unemployment rates for American Indians and Alaska Natives are not available;[13] however, rates are known to be high in many Native communities where economies are depressed and the number of available jobs is low. Common reasons for unemployment are lack of education, absence of jobs, and high rates of disabilities. Even when American Indians and Alaska Natives are similar to Whites in terms of factors such as age, sex, education, marital status, and place of residence, their odds of being employed are 31% lower than Whites.[14] This suggests the presence of factors that go beyond known conditions and include racial discrimination and geography. For example, American Indian and Alaska Native unemployment rates are lower in states with no reservations and higher in reservation states.

SANITATION FACILITY INFRASTRUCTURE.

Adequate sanitation facilities (running water and/or waste water disposal) is lacking in approximately 145,000 American Indian and Alaska Native homes which represent 36 percent of the universe of tribal homes tracked by the Indian Health Service.[15] In addition, many tribes with adequate sanitation facilities are struggling to properly operate and maintain the infrastructure and safely deliver services. Research in American Indian and Alaska Native communities has linked lack of adequate sanitation services with serious health conditions.[16]

POVERTY

Compared with all other races, American Indians and Alaska Natives are most likely to live in poverty (26.6% compared with 14.7% for the U.S. general population).[17] Furthermore, in studies of both urban and rural communities, American Indians and Alaska Natives are approximately twice as likely as the general population in those same areas to be poor, unemployed, and without a college degree.[18,19] In addition to the complexity of poverty and unemployment is the problem of underemployment. In environments where there is competition for employment (including both on reservations and in urban-based settings), American Indians and Alaska Natives may be economically forced to accept part-time or poorly paid work in lieu of no employment.[20]

MORBIDITY/MORTALITY

American Indians and Alaska Natives born today have a life expectancy that is 4.2 years less than all other races in the United States and continue to die at higher rates than others due to liver disease, diabetes mellitus, unintentional injuries, assault/homicide, and intentional self-harm/suicide.[21] Alcohol is considered to be the largest contributing factor to increased mortality,[22] and American Indians and Alaska Natives are approximately twice as likely to die of alcohol-related causes than the general American public.[23] However, there is significant variability for alcohol-specific deaths across American Indian and Alaska Native populations – from 17.0 per 100,000 in the Nashville Area to 83.4 per 100,000 in the Aberdeen Area.[24]

Historical and Intergenerational Trauma

Historical trauma is recognized as the root cause of much of the behavioral health disparities currently experienced by American Indians and Alaska Natives.[25]

Social injustices, perpetuated over multiple generations, have had enduring consequences for many American Indian and Alaska Native individuals, families and communities. Research documents massacres, genocidal policies, pandemics from the effects of introduced diseases, forced relocations, forced removal of children through boarding school policies, and prohibition of spiritual and cultural practices (including the prohibition of the use of Native languages).[26,27] Native youth who were removed from their homes were prohibited from communicating in the only language they knew – their Native language.

Maria Yellow Horse Brave Heart defines historical trauma as the collective complex trauma inflicted on a group of people who share a specific group identity or affiliation.[28,29,30,31] The symptoms and long-term effects of historical trauma include psychological distress, poor overall physical and mental health, and unmet medical and psychological needs,[32] evidenced by increased exposure to trauma, depressive symptoms,[33] substance misuse,[34] and suicidal thoughts and attempts.[35] Trauma affects individuals differently. In some cases exposure to traumatic events will not have lasting negative effects. However, in other cases people may experience traumatic stress reactions. If trauma is left unaddressed, the risk of mental and substance use disorders and chronic physical disease significantly increases.[36]

The intergenerational effects of historical trauma on long-term health have been documented among American Indian and Alaska Native populations through adverse childhood event (ACE) studies. These studies assess the prevalence of personal experiences – physical abuse, verbal abuse, sexual abuse, physical neglect, emotional neglect, and family experiences – for example, a parent with alcohol problems, a mother who has been a victim of domestic violence, a family member in jail, a family member with a mental disorder, or the loss of a parent through divorce, death, or abandonment. Higher scores are correlated with poorer long-term outcomes. In the report "A Framework to Examine the Role of Epigenetics among Native Americans," Brockie, Heinzelmann, and Gil[37] report that "Native Americans disproportionately experience ACEs and health disparities, significantly impacting long-term physical and psychological health."

Traumatic events experienced by American Indians and Alaska Natives are not confined to a single catastrophic period in the past, nor are they confined to a single event but from many sources; they are ongoing and present in modern times.[38,39] A history of unethical research authorized by the U.S. Government created distrust and reluctance on the part of tribes to engage in large-scale studies that could provide information specific to American Indians and Alaska Natives about problems such as alcohol use disorder, suicide, and depression.[40] Blood quantum requirements (also known as blood quantum laws), which originated in the Indian Reorganization Act of 1934 and were incorporated into many Tribal constitutions, create threats for future generations. Children of intertribal unions may not meet Tribal blood quantum requirements, thus eliminating their eligibility for Tribal membership and access to services.[41]

American Indians and Alaska Natives who are prosecuted in Federal courts face lengthier confinements than non-Natives prosecuted for the same crime in state courts[42] and are incarcerated at a rate higher than the national average.[43]

Native children are disproportionately represented in the foster care system and may be placed with non-Native families. For example, in South Dakota American Indian and Alaska Native children make up less than 15% of the child population, yet they represent more than half of the children in foster care.[44]

Although the symptoms and effects of historical trauma are well known, Native youth are neither likely to recognize that their present-life experiences, or modern-day traumas, are triggered by past events nor to make the connection to the root cause. This is despite the fact that American Indian and Alaska Native adolescents exhibit the effects of historical trauma through high suicide rates,[45] alcohol and other drug misuse as well as alcohol and other drug disorders,[46] and sexual risk-taking.[47]

Researchers studying the effects of historical trauma across generations of American Indians and Alaska Natives found that perceptions of historical trauma differed by age and generation. For example, in a study of Diné youth, parents, and grandparents, elders were much more aware of the long-term consequences of historical trauma and easily connected it to loss of cultural knowledge, high rates of disease, alcohol and other drug misuse, unhappiness, violence, premature death, and overall lack of health.[48] Although only one generation removed, the majority of elders' adult children did not think that the root cause of their adverse life conditions resulted from historical trauma and were more likely to view events such as community violence as temporally rather than historically linked. Two generations removed, the grandchildren of elders did not believe that historically traumatic events had any negative effects on their community or their own lives. Individuals in the study did not see themselves, their families, or their communities as subject to continued oppression through control by outsiders.[49] The perpetuation of self-destructive behaviors cannot be addressed or interrupted without a deeper understanding of how trauma impacted past generations and that it continues to impact present generations and is constantly triggered by the events, policies, and practices of modern times.

Despite historical and other traumas, American Indian and Alaska Native communities have managed to survive and some communities are thriving. During the 20th century American Indians and Alaska Natives rebuilt their nations, adapted to cultural and economic pressures, overcame adverse and destructive policies, and retained their place in the U.S. landscape.[50]

Time, history, and adversity have fostered inherent traits and beliefs that have engendered strong and resilient Native communities. An important value, and one that differs

widely from the dominant society, is the importance of the group, be it tribe, community, or family. Tribal leaders and decisionmakers deliberate on the welfare and needs of the group rather than focus solely on individuals. There is consideration and mindfulness of the ramifications of present-day decisions on children and grandchildren, across generations. Extended kinship networks often provide strength, protection, and support, particularly during times of hardship. The resources of the group, such as food, shelter, transportation, and money, are shared to provide for the well-being and safety of all.[51]

Tribal language and stories ensure that the tribe's worldview is passed on to the next generation. There are words, definitions, and understandings distinct to a tribe's language that help Native youth understand their place in the tribe and in the world. Creation stories and teaching stories preserve identity while instilling resilience factors and cultural and social norms. Shared beliefs about the importance of balance – spiritual, physical, mental, and emotional – provide a framework for protecting and preserving the Tribal community and helping ensure the long-term viability of the tribe. All of these characteristics combine to create a powerful and resilient practice of culture and serve as strong protective factors against adversity.

3 BEHAVIORAL HEALTH: STATE OF URGENCY

The information presented in this document paints a difficult picture and underscores the urgency to address behavioral health among Native people. When armed with facts, Tribal leaders are better able to have open discussions about strategies within their community contexts, which hold potential for overcoming behavioral health challenges. These challenges are evident through comparisons of Tribal communities with nontribal communities; however, this often fails to highlight the exceptionality of these challenges as they exist with the cultural, community, geographic, economic, and psychosocial realities of American Indian and Alaska Native communities.[52]

An Indigenous definition of health is ". . . not just the physical well-being of an individual, but refers to the social, emotional, and cultural well-being of the whole community in which each individual is able to achieve their full potential as a human being thereby bringing about the total well-being of their community."[53] American Indian and Alaska Native communities are aware of the physical health challenges of their people, but there are also behavioral health challenges that are often more difficult to discuss and that also impact overall health and well-being. These behavioral health challenges are associated with increased exposure to trauma, depressive symptoms,[54] substance misuse,[55] and suicidal thoughts.[56]

The list of exposures and outcomes assessed in this section is not necessarily exhaustive; rather, the information provided represent key factors for which plausibly representative data are available. There are many other factors that are potentially relevant here, but that are not adequately assessed via currently available data sources.

The following discussion of trauma identifies critical areas for targeted, renewed, or enhanced Tribal and Federal collaboration across programs, policies, and activities.

TRAUMA

INTERPERSONAL VIOLENCE (IPV)

Current rates of violent victimization for both American Indian and Alaska Native males and females in every age group are higher than for all other races. American Indian and Alaska Native females are at an elevated risk of intimate partner violence.[57, 58] Specifically, American Indian and Alaska Native women report higher rates of victimization on all measures of violence than their non-Hispanic White (NHW) counterparts, including rape, other sexual violence, stalking, and partner physical violence and psychological aggression. American Indian and Alaska Native men report higher rates of victimization than White/Non-Hispanic individuals in other sexual violence and partner physical violence and psychological aggression (TABLE 1).

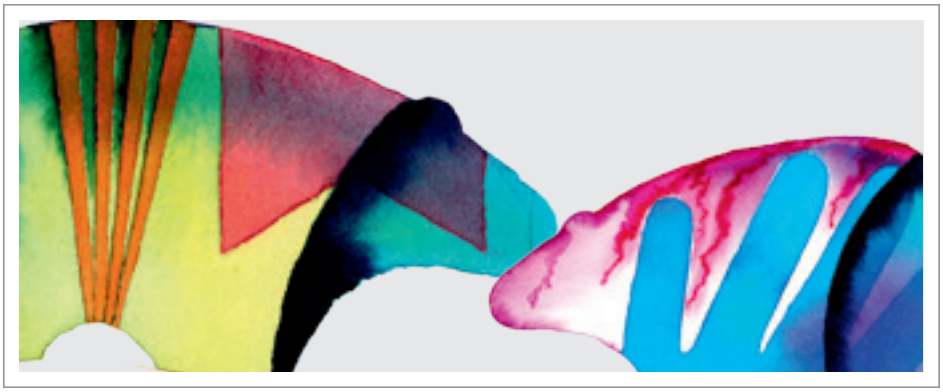


TABLE 1:

LIFETIME PREVALENCE OF SEXUAL VIOLENCE, STALKING VICTIMIZATION, AND INTIMATE PARTNER VIOLENCE
AI/AN VS. NON-HISPANIC WHITE ADULTS AGE 18+ – NISVS, 2011[A,B]

	WOMEN			MEN		
	%	95% CI	Estimated N	%	95% CI	Estimated N
WHITE NON-HISPANIC						
Rape	20.5	18.8-22.3	16,475,000	1.6	1.2-2.2	1,232,000
Other Sexual Violence	46.9	44.9-48.9	37,661,000	22.2	20.5-24.1	16,846,000
Stalking	15.9	14.4-17.5	12,749,000	4.7	3.9-5.8	3,581,000
IPV: Rape	9.6	8.4-10.9	7,730,000	--	--	--
IPV: Other Sexual Violence	17.1	15.6-18.7	13,710,000	7.6	6.5-8.9	5,777,000
IPV: Physical Violence	30.5	28.6-32.4	24,469,000	26.6	24.8-28.6	20,190,000
IPV: Stalking	9.9	8.6-11.3	7,935,000	1.7	1.3-2.3	1,279,000
IPV: Psychological Aggression	47.2	45.2-49.2	37,888,000	44.8	42.7-46.9	33,959,000
AMERICAN INDIAN/ALASKA NATIVE						
Rape	27.5	16.1-42.7	--	--	--	--
Other Sexual Violence	55.0	41.5-67.9	452,000	24.5	13.5-40.3	--
Stalking	24.5	14.2-38.8	--	--	--	--
IPV: Rape	--	--	--	--	--	--
IPV: Other Sexual Violence	--	--	--	--	--	--
IPV: Physical Violence	51.7	38.1-65.0	424,000	43.0	27.4-60.1	335,000
IPV: Stalking	--	--	--	--	--	--
IPV: Psychological Aggression	63.8	50.4-75.3	523,000	47.2	31.1-64.0	368,000

a Estimates from Breiding, M. J. (2014). Prevalence and characteristics of sexual violence, stalking, and intimate partner violence victimization – National Intimate Partner and Sexual Violence Survey, United States, 2011.

b This data collection does not allow estimates for all measures due to low sample sizes, and these comparisons have not been subjected to inferential testing.

American Indians and Alaska Natives fall victim to violent crime at more than double the rate of all other U.S. citizens,[59] and at least 70% of violent victimization experienced by American Indians and Alaska Natives is committed by non-Natives and usually while they are drinking. Nearly one-third of all American Indian and Alaska Native victims of violence are between the ages of 18 and 24 years, and about one violent crime occurs for every four persons of this age.[60] The combination of interpersonal violence layered over historical trauma creates compound negative effects for American Indians and Alaska Natives.

ADOLESCENTS AND VIOLENCE

Teen exposure to violence is associated with multiple adverse health outcomes, including depression, anxiety, suicidal ideation, substance use, posttraumatic stress disorder (PTSD), risky sexual behavior, and eating disorders.[61,62,63,64,65,66,67,68] To add to the limited information about American Indian and Alaska Native adolescents and violence, Morsette and colleagues studied exposure to violence and trauma among 302 American Indian and Alaska Native middle-school students and found that 77.5% had clinically significant levels of psychometrically assessed violence exposure and 52% had clinically significant levels of PTSD.[69] Unwittingly, Native teens are experiencing the effects of historical trauma and in turn are reporting emotional and behavioral problems.

CHILDREN OF INCARCERATED PARENTS

Research regarding American Indian and Alaska Native children of incarcerated parents is derived from larger studies with no specific data for American Indian and Alaska Native children despite high rates of American Indian and Alaska Native adult incarcerations.[70,71,72,73,74] In an unpublished review of risks among 1,184 American Indian and Alaska Native students attending BIA residential boarding schools, 25% reported having a parent who had been incarcerated.[75]

Having an incarcerated parent can impact a child's mental health, social behavior, and educational prospects. Children may experience emotional trauma, a disrupted family life, and discrimination as a result of having a parent in prison or jail.[76] Financial hardship follows the loss of that parent's income,[77] and if parental rights are terminated, children may lose not only the parent but also the connection to their entire family if they are placed in foster care.[78]

Children of incarcerated parents may experience trauma related to their parent's arrest or events leading up to it[79] and are more likely to have faced other ACEs, including witnessing violence in their communities or directly in their household or exposure to alcohol and other drug misuse.[80] Due to the long-term negative effects of historical trauma across generations that have resulted in high rates of incarceration for American Indian and Alaska Native people, children are now experiencing historical trauma in new and current forms.

VETERANS

American Indian and Alaska Native males who serve in the U.S. Military do so in greater proportion than all eligible males in general – 3% of all American Indian and Alaska Native males, ages 20 to 44 years, compared with 2% of all U.S. males (all races) in the same age group. The U.S. Department of Defense reported that more than 24,000 active duty military personnel (out of the 1.4 million total personnel) were American Indians and Alaska Natives, including 3,900 women. There are more American Indian and Alaska Native women veterans (11.5%) than veteran women of other races (8.0%).[81] It is estimated that 22% of Native Americans age 18 years and older are current veterans,[82] and the population of older American Indian and Alaska Native veterans will likely increase 60% by 2020.[83]

In a study of Vietnam veterans and the long-term effects of exposure to war zone stress and other military dangers, researchers found that veterans are at risk for PTSD decades after exposure. They also found that PTSD rates for Native American Vietnam veterans are higher than for their White counterparts.[84,85] High rates of alcohol use disorder among veterans may be the result of the use of alcohol to self-soothe psychiatric distress related to PTSD symptoms.[86,87] Survey data from the *American Indian and Alaska Native Veterans: 2013 American Community Survey* showed that American Indian and Alaska Native veterans were more likely to lack health insurance and to have a disability, service-connected or otherwise, than military veterans of other races.[88] The likelihood of American Indian and Alaska Native veterans being more likely to lack health insurance may be related their dual status – their potential eligibility to receive health care at an Indian Health Service or Tribal Health Program facility as well as a U.S. Veterans Administration health care facility.

DEPRESSIVE SYMPTOMS

DEPRESSION

In general, American Indians and Alaska Natives have comparatively poorer behavioral health. Although there are no large-scale studies to determine the prevalence of depression and other common mental health concerns among American Indian and Alaska Natives, available data indicate that problems exist at disproportionately high rates for both urban and reservation American Indians and Alaska Natives[89] and that approximately 30% of Alaska Natives in particular will suffer from depression at some point in their lifetimes.[90] Data from the 2015 National Survey on Drug Use and Health indicate that American Indian and Alaska

Native adults aged 18 and older experienced higher rates of past year mental illness compared with the general population (21.2% versus 17.9%).

Among U.S. adolescents ages 12 to 20, American Indians and Alaska Natives had the highest lifetime major depressive episode prevalence and the highest major depressive episode prevalence in the past year.[91] Among 9,464 children participating in a depression study, American Indian and Alaska Native children had the highest self-reported depression rates, and depression increased with age, peaking between 16 and 17 years of age. In the same study, race was analyzed as an independent risk factor, and results showed that simply being American Indian or Alaska Native, apart from any other factor, increased the rate of depression 2.6-fold.[92]

Despite the need, service utilization rates for American Indians and Alaska Natives are low,[93] which is likely due to a combination of factors, including stigmatization, lack of culturally trained providers, lack of services, and discrimination.[94] Low utilization rates may also be due to a misalignment between the world views of American Indian and Alaska Native peoples and that of the behavioral health field. Anecdotal evidence suggests that when services are culturally based (e.g., a tribal system of care), utilization increases.

GRIEF AND LOSS

The quality and intensity of interpersonal attachments within most American Indian and Alaska Native communities differ from the broader society, due in part to an extensive, complicated, and close-linked kinship network in Native communities. Higher morbidity and mortality rates, lower life expectancy, and higher rates of suicide and accidental death among American Indians and Alaska Natives often result in the loss of one or more family members annually.[95] As an example, among American Indian and Alaska Native youth attending a residential boarding school, 58% reported the loss of one or more close family members within the preceding 12 months.[96]

Unresolved grief may lead to depression or PTSD. Researchers have found that individuals who are grieving are also at increased risk of death due to accidents, violence, and alcohol-related causes and are more likely to attempt suicide (fatal and nonfatal).[97]

SUBSTANCE MISUSE

Determining universal rates and risks of substance misuse for American Indians and Alaska Natives is difficult due to the diversity and geographical dispersion of American Indian and Alaska Native populations.[98,99] Overall, the rate of alcohol consumption among American Indians and Alaska Natives is significantly lower than the national average (43.9% vs. 55.2%, respectively).[100] However, there are differences by region and tribe. Some American Indian and Alaska Native communities have low rates, and others have distinctly higher rates.[101,102,103] American Indians and Alaska Natives who reside in urban or suburban areas, on average, drink more frequently than reservation-based American Indians and Alaska Natives and more heavily than the national sample and may be at particularly high risk for alcohol-related disorders.[104] Diversity in rates and patterns of use across American Indian and Alaska Native groups is often due to substance availability, finances, presence of substance-misusing peers, and attitudes toward substance misuse.[105]

Although rates and risks vary across tribes, there is a body of knowledge that informs on patterns of use by American Indian and Alaska Native youth. In particular, youth on reservations are at the highest risk of developing alcohol-related disorders.[106] The 2013 Youth Risk Behavior Survey (TABLE 2) shows that American Indian and Alaska Native youth had higher rates of drinking alcohol before age 13 compared to national rates (28.2 compared to 18.6 respectively). Data from the American Drug and Alcohol Survey administered to Native youth at 33 schools from 2009-2012 was compared to data from the Monitoring the Future Survey. The comparison showed much higher prevalence of drug and alcohol use amongst 8th and 10th grade Native youth in comparison to national averages.[107] Early substance use may result from stress events, and is a clear marker of risk for prolonged and problematic use,[108,109,110] along with lower academic achievement, academic problems, drug use, and alcoholism later in life.[111]

TABLE 2:

AI/AN VS. NATIONAL YOUTH ALCOHOL USE DATA, YOUTH RISK BEHAVIOR SURVEY 2013[A]

Alcohol Use	National	AI/AN
Ever had at least one drink of alcohol	66.2 (63.7–68.5) 13,104	70.0 (58.0–79.8) 113
Drank alcohol before age 13 years	18.6 (17.2–20.0) 13,308	28.2 (17.0–42.9) 114
Currently drank alcohol	34.9 (32.8–37.1) 12,288	33.4 (23.9–44.4) 101
Usually obtained the alcohol they drank by someone giving it to them	41.8 (39.4–44.1) 4,239	N/A 33
Had five or more drinks of alcohol in a row	20.8 (19.1–22.7) 13,060	18.3 (11.7–27.5) 109
Reported that their largest number of drinks in a row was 10 or more	6.1 (5.2–7.1) 12,363	6.1 (2.5–14.2) 101

[a] Comparisons have not been subjected to inferential testing.

American Indians and Alaska Native crime victims report higher rates of offender alcohol/drug-involved violent victimizations than individuals who are not Native American (TABLE 3)

Drug overdose deaths from opioid misuse are of significant concern to Tribal communities. The Northwest Portland Area Indian Health Board reported that from 2006 to 2012, a total of 10,565 deaths occurred among American Indian and Alaska Native residents in the states of Idaho, Oregon, and Washington. There were 584,070 deaths among non-Hispanic White (NHW) in the three-state region. Drug overdoses accounted for 4.3% (450) of all deaths among Northwest American Indians and Alaska Natives and 1.7% (9,868) of all deaths among NHWs. Of the drug overdose deaths, 65.3% (294) of American Indian and Alaska Native deaths and 69.3% (6,837) of NHW deaths were from prescription drugs. Furthermore, of the prescription drug overdose deaths, 77.2% (227) of American Indian and Alaska Native deaths and 75.4% (5,157) of NHW deaths were from opioid overdoses.[112]

A 2011 Great Lakes Inter-Tribal Council community assessment reflecting aggregated data from 10 Tribal nations, found that:[113]

- 30.9% of youth, 27.7% of minor adults, and 24.9% of adults intentionally misused prescription medication.
- 7.6% of youth think there is no risk in misusing prescription drugs; another 5.9% think there is only a slight risk.
- 5.2% of survey responders indicated it is very likely they will misuse prescription drugs in the next 6 months; another 6% indicate it is somewhat likely.
- 15.6% of youth, 34% of minor adults, and 28.1% of adults indicate it would be very easy for them to obtain prescription drugs without a prescription if they wanted them.

According to SAMHSA's Treatment Episode Data Set (TEDS), in 2012 there were about 1.7 million individuals admitted to substance use treatment facilities. Of these, 43,576 (2.5%) were American Indians and Alaska Natives. Approximately 77% of American Indian and Alaska Native individuals admitted reported alcohol misuse. Twenty-three percent of the American Indian and Alaska Native admissions were ages 15 to 24 years, and among this age group, 68.5% (6,885) reported alcohol misuse. Among American Indian and Alaska Native individuals who were admitted and misused alcohol only 80.5% (21,008) of them reported being first intoxicated at age 17 years or younger.

SUICIDE

Studies show that both American Indian and Alaska Native adults and adolescents suffer from high rates of suicide. In 2011 the suicide rate for all American Indians and Alaska Natives was 14.68 per 100,000 compared with the overall U.S. rate of 11.15 per 100,000.[114] American Indian youth experience the highest rates of youth suicide in the country, and suicide is the second leading cause of death. In 2012-2013, the suicide rate for American Indian and Alaska Native young adult males was 34.3 per 100,000 compared to 24.8 for non-Hispanic White males in the same age

TABLE 3:

VIOLENT VICTIMIZATION RATE, BY VICTIM PERCEPTION OF OFFENDER'S ALCOHOL/DRUG INVOLVEMENT
NATIONAL CRIME VICTIMIZATION SURVEY (NCVS) 2004-2013[A,B]

Violent Victimization Rate*		Offender Alcohol/Drug Involved		
RACE OF VICTIM**	**TOTAL**	**YES**	**NO**	**DON'T KNOW**
All races	25.57	8.35	7.95	9.27
AI/AN	76.94	31.75	18.59	26.60
Non-AI/AN				
White – Non-Hispanic	25.14	8.71	7.96	8.48
Hispanic	22.85	6.38	7.01	9.46
Black – Non-Hispanic	31.23	7.85	9.62	13.76
Asian/Pacific Islander – Non-Hispanic	11.70	3.62	3.43	4.65
Two or more races – Non-Hispanic	166.31	29.82	83.60	52.89

Proportions		Offender Alcohol/Drug Involved		
RACE OF VICTIM	**TOTAL**	**YES**	**NO**	**DON'T KNOW**
All races	100%	33%	31%	36%
AI/AN	100%	41%	24%	35%
Non-AI/AN				
White – Non-Hispanic	100%	35%	32%	34%
Hispanic	100%	28%	31%	41%
Black – Non-Hispanic	100%	25%	31%	44%
Asian/Pacific Islander – Non-Hispanic	100%	31%	29%	40%
Two or more races – Non-Hispanic	100%	18%	50%	32%

[a] NCVS, Bureau of Justice Statistics (BJS), Department of Justice (DOJ) and the Uniform Crime Reporting (UCR), Federal Bureau of Investigation, DOJ.

[b] Comparisons have not been subjected to inferential testing.

* Violent victimizations include rape or sexual assault, robbery, aggravated assault and simple assault. The rate is defined as victimizations per 1,000 persons age 12 or older.

** The race/Hispanic origin categories used in this table are defined differently than those found in BJSreports. The AI/AN category includes persons who self-identified as being AI/AN, regardless of whether they also identified as being other races or Hispanic origin as well.

group. For American Indian and Alaska Native young adult females the rate was 9.9 per 100,000 compared to 5.5 for non-Hispanic White females 18-24. A 2008 Centers for Disease Control and Prevention study estimated that overall deaths for American Indians and Alaska Natives was underreported by 30% thus the suicide rate for American Indian and Alaska Native young adults are expected to be under estimated.[115] For Alaska Natives, suicide is the fourth leading cause of death, with a rate 3.6 times greater than the White population.[116]

Contributing factors to suicide risk for some American Indians and Alaska Natives may stem from persistent unemployment, poverty, poor educational outcomes, victimization, mental and substance use disorders, and/or exposure to violence.[117] In one study 77% of American Indian and Alaska Native males who had attempted suicide (fatal and nonfatal) had incomes of less than $10,000 per year, and 79% of them were unemployed.[118,119] Adults who attempt suicide (fatal and nonfatal) increase the suicide risk for their children by 20%.[120] American Indian and Alaska Native youth report higher rates of having felt sad or hopeless, seriously considered attempting suicide, or made a plan about how they would attempt suicide (TABLE 4). Risks for American Indian and Alaska Native youth include exposure to multiple childhood traumas,[121] sexual and physical violence,[122] and family conflict.[123]

TABLE 4:

YOUTH RISK BEHAVIOR SURVEY (YRBS) 2013[a]

Suicide-Related Behaviors	National	AI/AN
Felt sad or hopeless	29.9 (28.3–31.6) 13,495	38.8 (28.9–49.7) 120
Seriously considered attempting suicide	17.0 (15.8–18.2) 13,491	27.4 (19.5–36.9) 120
Made a plan about how they would attempt suicide	13.6 (12.3–15.0) 13,485	23.1 (15.5–33.0) 120
Attempted suicide	8.0 (7.2–8.9) 11,982	N/A 98
Attempted suicide that resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse	2.7 (2.3–3.1) 11,750	N/A 90

[a] Comparisons have not been subjected to inferential testing.

4 HEALTH CARE AND SUPPORTIVE SERVICE CONSIDERATIONS

INDIGENOUS HEALING PRACTICES

Researchers who have interviewed American Indians and Alaska Natives across time and place about behavioral health report that, despite cultural and geographical differences, participants consistently referred to historical trauma and healing in discussions about mental health.[124] These terms focus on the group experience and describe an alternative perspective to illness and treatment when compared with typical Western practice, which tends to "reduce suffering to discrete illnesses with individually based causes and solutions." Holistic healing of a person within the context of their family and community is typically the emphasis within many Indigenous cultures.[125,126,127] Historical and anecdotal knowledge also tells of how tribes have been engaged in healing practices through the use of ceremony and traditional medicines for centuries that have been effective at promoting health, stemming illness, and reinforcing balance in the individual and community. These practices include prayer, the use of herbs and plants for medicinal purposes, and ceremonies that evoke spiritual support for individual and community health.

INTEGRATION OF TRADITIONAL AND WESTERN PRACTICES

Traditional healing practices and ceremonies are important sources of help to many American Indians and Alaska Natives; however, the integration of these approaches with Western biomedical services is often tenuous,[128] with tension between traditional and Western providers.[129] At the same time, researchers are increasingly aware of the need for integrated care[130,131,132,133] and consideration of historical trauma.[134,135,136,137,138,139,140,141] Historical and anecdotal knowledge should be integrated with science-based medicine and measurement-based care. Scientifically rigorous assessment of efficacy and effectiveness must always be respectful and culturally competent – reflecting each tribal communities' and their individual members' concepts of illness and treatment objectives – in order to extend to tribal communities the same entitlement to high-quality, evidence-based practices for which other parts of the US health system are increasingly held to account. Important support for integrated behavioral health is the currently accepted evidence-based practice of the American Psychological Association[142] which calls for integration of cultural beliefs, values, and preferences into the treatment decisionmaking process.

The IHS issued a special memorandum in 1994 affirming its organizational commitment to protect and preserve the right of all American Indians and Alaska Natives to exercise their traditional practices and stating that IHS employees should also demonstrate respect for these practices.[143] In addition, other Federal agencies recognize and support the inclusion of traditional healing practices through grant programs and initiatives. Some tribes have made strides and have been quite successful in formalizing the integration of traditional healing practices into their health facilities, services, and programs to improve the well-being of their communities. Through the American Indian and Alaska Native Cultural Wisdom Declaration that is part of this document tribal nations are seeking greater support for inclusion of traditional practices as fundamental to effectively implementing funded programs in their communities.

Recovery from substance use disorder is taking place with the assistance of culturally specific methods in American Indian and Alaska Native communities in North America. Many of these communities not only utilize recovery approaches that make up today's best practices but also use their own cultural and ethnic strengths as an important part of their substance use discorder recovery.[144] Some of the most promising suicide prevention approaches involve evidence-based, trauma-informed interventions integrated with practices that promote Tribal language, culture, and traditional healing.[145] Tribal and youth regional treatment centers engage in varying degrees of integrated care to address substance use treatment and relapse prevention.

COMPONENTS OF INTEGRATED INTERVENTIONS

Interventions focused on individuals, families, and communities should occur early and be intergenerational. Content may include teachings on traditional narratives, beliefs, and practices: address historical events in culturally appropriate ways; and, relate them to current conditions and family dynamics. Activities should emphasize active skills-building; facilitate communication and interaction among elders, parents, and youth; and those at the community level should avoid addressing more than one issue at a time. Traditional knowledge and practices should be incorporated into care based on the preferences of the Tribe.[146]

COMPONENTS OF INTEGRATED SYSTEMS

An integrated system links prevention and treatment systems and includes a flexible approach to provider-client and provider-patient relationships that allows for adaptive treatment approaches.[147] Staff members should be educated and culturally competent, and the community should be involved in implementing structural changes to affect surrounding conditions.[148,149]

HEALTH CARE AND SERVICE SYSTEMS

American Indians and Alaska Natives receive health care services through multiple sources, including the IHS, tribally operated facilities, urban Indian health care programs, the U.S. Veterans Administration (VA), private health care systems, and Federally Qualified Health Centers (FQHCs).[150] The IHS is one of the primary Federal agencies responsible for fulfilling the Federal Government's health care obligation to American Indian and Alaska Native tribes. Through treaty agreements with Tribes, the Federal Government has committed to provide health care to American Indians and Alaska Natives, primarily in exchange for ceded land. To fulfill this component of the Federal Government's trust responsibility to tribes and Tribal members, a unique health care system has evolved that allows American Indians and Alaska Natives to receive physical and behavioral health services through a variety of mechanisms.

IHS, an HHS agency, is charged with providing primary care and behavioral health services to American Indians and Alaska Natives living on or near reservations. There are 12 regional service areas within the Indian Health Care System. Within IHS, the Division of Behavioral Health oversees programs that focus on alcohol and other substance use prevention, domestic violence prevention, forensic health care, mental health, methamphetamine use prevention, suicide prevention, telebehavioral health, and Youth Regional Treatment Centers (YRTCs).[151]

The IHS and tribes provide primary medical care and community health services mainly in small, rural communities in more than 660 locations across 36 states, including 45 hospitals, 617 ambulatory facilities (343 health centers, 111 health stations, 163 Alaska Native village clinics,[152] and 34 urban programs. These facilities can be grouped into three categories:

- Facilities operated directly by IHS
- Facilities operated by tribes through a Tribal Health Authority (THA) by contract or compact with IHS
- Programs managed by urban Indian health programs to provide services to American Indians and Alaska Natives in certain urban areas

Tribes that receive health services from a facility operated directly by IHS are known as *direct service tribes,* and tribes that manage their own health systems are known as *self-governance tribes.* Many tribes are also served by community health (e.g., childhood immunizations, home visits) and environmental health (e.g., sanitation, injury prevention) programs, which may be administered by IHS or THA. Specialty services and types of medical care that are not available at a given facility are purchased from providers in the private health sector through a program that is now known as *purchased and referred care* (PRC).[153]

TABLE 5:

FY 2014 IHS ANNUAL PATIENT SERVICES	
Inpatient Admissions	44,677
Outpatient Visits	13,180,745
Alcohol and Substance Use Outpatient Visits	87,947
Mental Health Client Service Encounters	490,994
Alcohol and Substance Use Inpatient Days	8,238
YRTC Number of Youth Served (FY 2012)	915
Average age	15.8 years

The IHS and THAs apply stringent eligibility criteria to determine which patients qualify for PRC funding. The severely limited pool of PRC dollars also means that most PRC programs limit reimbursements for those diagnostic or therapeutic services needed to prevent immediate death or serious health consequences. Among other problems, this results in reduced access to screening services and contributes to increased mortality.

American Indians and Alaska Natives living in urban communities have been referred to as a "population in crisis" given their extreme poverty, poor health, and cultural isolation.[154] Their status is compounded by a number of factors, including lack of access to health services that are located on or near reservations, transportation challenges, distrust of government services, and risk of receiving mediocre or poor-quality care. Currently, there are 34 Urban Indian Health Programs supported through IHS. These urban Indian programs are eligible for FQHC status, and approximately 45% receive Medicaid reimbursement.

WORKFORCE DEVELOPMENT

Lack of mental health services may in part be attributable to a shortage of behavioral health service providers. Barriers to recruitment include funding disparities across IHS regions, lack of opportunity to maintain skills, lack of opportunity for professional growth, lack of exposure to best practices and new developments, isolated work locations, highly stressful work environments, and a lack of support staff members. For example, across IHS there are 16 allocated psychiatric nursing positions located in Alaska and Navajo Areas.[155] The vacancy rate for these positions averaged 38% over calendar year 2010, demonstrating the difficulty in filling these positions.[156]

Developing a clinically skilled and culturally competent behavioral health workforce for Tribal communities lies in improving the pathways for Native young people to seek educational and training options that are accessible to them, both community-based, onsite and online. Providing avenues to advanced training and college education as well as working to improve existing school systems will assist in moving toward a culturally competent skilled workforce with an understanding of the attitudes, issues, and concerns of Native populations.

TABLE 6:

IHS 2016 EMPLOYEES	
Total	15,369
Nurses	2,648
Physicians	725
Pharmacists	698
Engineers/Sanitarians	110
Physician Assistants	115
Dentists	272
Behavioral Health Providers	Over 500

INDIAN HEALTH CARE SYSTEM FUNDING

The Indian Health Care System is supported through annual congressional appropriations. The fiscal year (FY) 2016 IHS funding was $6.2 billion and includes slight increases for mental health and alcohol treatment programs. Approximately 98% of the IHS budget for direct health services is focused primarily on serving American Indians and Alaska Natives who live on or near reservations. The IHS budget specifically focused on supporting urban Indian health clinics represents the remaining 2% of the budget for health services. Many programs are also dependent on grant funding, Tribal revenue, and collections from third-party payers (e.g., Medicaid) to remain financially viable.[157] IHS estimates it receives 22% of the funding needed for the Urban Indian Health Program.

Historical estimates document per capita expenditures for health care for American Indians and Alaska Natives at less than half of those for Medicaid and lower than all other federally funded health systems, including prisons.[158] Former North Dakota Senator Byron Dorgan, who chaired the U.S. Senate Committee on Indian Affairs for 18 years, has expressed concerns that IHS, which serves the Nation's 567 tribes, has persistent funding challenges. "We need more mental health services to save the lives of our youngest First Americans," Senator Dorgan said. "Tribes and nonprofits may get two- or three-year grants to address an issue that cannot possibly be resolved in that amount of time."[159]

OTHER IMPORTANT FEDERAL SOURCES OF FUNDING

Tribes that operate their own health systems also invest in their systems beyond funds received through 638 compacts, contracts, and reimbursements from Medicare, Medicaid, and private insurance. In addition, tribes are eligible for grants, contracts, and other support from Federal agencies across the Executive Branch.

Federal departments and agencies such as SAMHSA, ACF, ACL, HRSA, DOJ, and others support programs that address one or more of the following health, safety, and/or wellness areas: suicide prevention; alcohol and other drug use prevention; services for Tribal youth that promote prevention, treatment, and recovery from mental and substance use disorders; services for pregnant and postpartum women with substance use disorders; development of systems of mental health services for children with serious emotional disturbances; early childhood development; Native language preservation and maintenance; economic self-sufficiency; Tribal healing to wellness courts that provide substance use treatment; domestic violence prevention; workforce training, development, and certification; and many other programs. Descriptions of some Federal programs are provided in *Part Two* of this document. These and other funding opportunities support Tribal efforts to more comprehensively address factors that impact the behavioral health and wellness of Tribal communities.

ACCESS TO SERVICES

The Affordable Care Act (ACA) created a new portal to health care services for more than 500,000 American Indian and Alaska Native people. Those earning between 100% and 400% of the Federal poverty level may be eligible for advance premium tax credits and could qualify for zero or limited cost sharing plans under the Health Insurance Marketplace. And, many American Indians and Alaska Natives with low to no income (up to 138% of Federal poverty level) are now eligible for Medicaid if they live in a state that has expanded coverage. The ACA's amendments to the Indian Health Care Improvement Act expanded the types of services facilities can offer and included behavioral health services. With greater numbers of American Indians and Alaska Natives receiving some form of coverage, IHS will be better able to provide needed health care services.[160,161] The ACA has altered the landscape of service delivery by increasing the opportunity for access to much needed services.

The IHS is designated as a "payer of last resort," meaning that Medicare, Medicaid, and private insurance companies are billed before IHS is required to pay for medical costs. Medicare, Medicaid and private insurance payments help to cover IHS and Tribal health care expenses without a reduction in IHS appropriated funding.

AVAILABILITY AND QUALITY OF SERVICES

The availability of IHS services varies by location. Most IHS clinics are in rural areas, and thus access to those clinics is limited for the large urban American Indian and Alaska Native population. Services and the availability of services also vary from service unit to service unit, often creating an unreliable and unpredictable level of care for those in Tribal or urban communities. Services are performed by both licensed and unlicensed health care providers.[162,163,164,165] All services, including public health, behavioral health care, and medical care, often are provided by an amalgam of IHS, Tribal, county, state, and nonprofit organizations.[166,167] Distances to service providers, as well as insufficient resources for fuel and childcare, impact American Indian and Alaska Native use of services.[168]

In a study of 514 IHS and Tribal facilities, 82% reported providing some type of mental health service such as psychiatric services, behavioral health services, substance use treatment, or traditional healing practices, and to improve access, 17% (87) have implemented telemedicine for mental health services.[169] However, none provide inpatient psychiatric services. Without access to care, persons in psychiatric distress often end up in the hospital emergency department.[170]

Concerns regarding the quality of care available to American Indians and Alaska Natives have been raised.[171] Significant efforts are underway to ensure the quality of care throughout the Indian Health Care System. These efforts include improvement, enhancement, modernization, and increased security of the health information technology system used for patient data; establishment of the IHS Quality Consortium to coordinate quality improvement activities among hospitals and clinics; addressing workforce shortages; and improving infrastructure.[172]

In an effort to examine and prioritize behavioral health quality prevention, treatment, and recovery elements, SAMHSA developed the National Behavioral Health Quality Framework (NBHQF). The NBHQF is a document that guides the identification and implementation of key behavioral health quality measures that support funding decisions, monitoring of behavioral health, and delivery of behavioral health care. The framework is aligned with the National Quality Strategy and supports the three aims of better care – healthy people, healthy communities, and affordable care. The NBHQF also provides for dissemination of proven interventions and accessible care, which includes the affordability of care and the impact of health disparities.

ATTITUDES TOWARD BEHAVIORAL HEALTH AND SERVICES

Individual, systemic, and cultural barriers influence decisions about accessing behavioral health services. Within many American Indian and Alaska Native communities, there is a wide range of cultural beliefs surrounding mental health. For some American Indian and Alaska Native tribes, speaking about negative things such as depression, suicide, and other mental disorders invites these things into their world, so such discussions are forbidden, avoided, or discouraged.

Researchers have found that culture plays an important role in one's attitudes toward psychotherapy,[173,174] decisions about starting treatment,[175] premature termination of treatment,[176,177] and eventual treatment outcome.[178,179] Across racial and ethnic groups, research indicates that attitude toward treatment is one of the best predictors of treatment use.[180,181,182]

SUPPORTIVE SERVICES

The Bureau of Indian Affairs' social services program supports an array of social service activities that strengthen Indian families, promotes family stability, and ensures health and well-being. The social services program manages applications for financial assistance, delivers child and adult protective services, provides services to children and families affected by alcohol and substance use and domestic/family violence, provides technical assistance and training to tribal contractors on regulatory issues and best practices, and fulfills the BIA's fiduciary responsibility of managing supervised Indian Individual Monies (IIM) accounts.

BIA funding for tribal Indian Child Welfare Act (ICWA) programs support social workers that work with tribal courts, state courts, and Indian families in the areas of child protection. Children are reunified with their families when possible. When reunification is not possible, children are placed into Indian foster and adoptive homes.

BIA maintains a comprehensive plan for addressing the needs of Indian communities with high rates of domestic and family violence, and high incidences of child abuse and neglect. The plan focuses on strategies to expand family services related to domestic and family violence; improve collaboration and coordination between law enforcement and social services to more rapidly address instances of domestic and family violence and improve coordination of services with other tribal, state, and federal partners on domestic and family violence initiatives/activities in Indian Country. The plan also includes a gap analysis and best practices model; developing and scheduling domestic violence training; visiting Tribal domestic and family violence programs to learn more about their work, and providing technical assistance to tribes operating domestic violence/family violence prevention programs.

The Tiwahe Initiative was recently launched by BIA as a means for more holistically delivering services. The Tiwahe Initiative is a five-year comprehensive plan to strengthen Indian families and promote family stability in order to fortify tribal communities. The Tiwahe Initiative is a demonstration project and seeks to show how integration in the delivery of services to children, youth, and families will help preserve the family unit and support healthy and productive families. Under the Tiwahe Initiative, each Tiwahe site will be required to develop and submit a plan for an integrated service delivery model that is centered on the needs of their tribal community and addresses the interrelated problems that are often a result of child abuse and neglect, poverty, family violence, substance misuse, unemployment, and incarceration in American Indian and Alaska Native communities.

PUBLIC HEALTH AND RESEARCH INFRASTRUCTURE

There have been well-documented reports of breaches in research ethics,[183] violations of participants' rights,[184] and lack of respect for cultural practices in research. This has led to an understandable wariness of Western research on the part of American Indians and Alaska Natives. In addition, the comparatively small number of American Indian and Alaska Native researchers has limited research-based knowledge development on matters of health in Indian Country. This realization has led to a revitalization of research in Indian Country but with more Tribal control.

Recent publications on research ethics in Indian Country have held that community-based participatory research (CBPR) is the gold standard for how studies should be conducted, which may not always result in evidence similar to a randomized controlled trial.[185,186,187] CBPR is a partnership in which the community is treated as a full and equal partner in all stages of research including, study design, data collection, analysis, and dissemination/application of results. Because of the history of unethical research in Indian Country, CBPR is a helpful strategy to support communities in healing from historical trauma and past research abuses. CBPR itself can be healing for a community through the process of taking ownership of research and data collection, and then determining how to use that information in line with principles of tribal sovereignty.

The Native American Research Centers for Health (NARCH) program is a collaboration between NIH and IHS. NARCH supports partnerships between American Indian and Alaska Native tribes or tribally based organizations and institutions that conduct academic biomedical and behavioral research. NARCH is a grant program that provides opportunities for conducting research, research training, and faculty development to meet the needs of American Indian and Alaska Native communities.

There are 12 Tribal Epidemiology Centers (TECs) that work to improve the health of American Indians and Alaska Natives by identifying and understanding health problems and disease risks, strengthening public health capacity, and developing solutions for disease prevention and control.[188] These TECs have made progress in documenting the health problems facing American Indians and Alaska Natives and work regionally and nationally to design and evaluate culturally relevant health interventsions.[189]

More and more tribes are taking an active role in public health practice and research in their communities. As an exercise in Tribal sovereignty and an acknowledgment that respectful research is still needed to advance the state of tribe-specific knowledge, a growing number of tribes have initiated their own Tribal review processes to govern research efforts undertaken on Tribal lands and with Tribal members. Other tribes are undertaking grant-funded collaborations with academic researchers and Federal agencies and active collaborations with state and county health departments. Many of these collaborations are based on the fundamentals of CBPR, which provides a critical impetus for the development of interventions that build on cultural, community, and individual strengths to promote positive outcomes for American Indians and Alaska Natives.[190]

5 THE NATIONAL TRIBAL BEHAVIORAL HEALTH AGENDA

The Historical and Current Contexts section of this document underscores the importance of developing the TBHA. That is, the contexts and factors that must be considered in an effort to improve the behavioral health of American Indians and Alaska Natives are complex and must be understood to create a blueprint for meaningful change. Ultimately, the intent is to help construct a more informed and productive path forward.

THIS PART OF THE DOCUMENT PROVIDES THE FRAMEWORK FOR THE TBHA BASED ON:

- TRIBAL INPUT
- INFORMATION FROM SELECTED FEDERAL STRATEGIC PLANS AND DOCUMENTS THAT PRESENT EXISTING PATHWAYS ON WHICH TO BUILD MORE COLLABORATIVE ACTIVITIES
- EXAMPLES OF EXISTING FEDERAL PROGRAMS THAT SUPPORT THE WORK THAT TRIBAL LEADERS AND TRIBAL REPRESENTATIVES BELIEVE ARE CRITICAL FOR SUPPORTING THE WELL-BEING OF THEIR COMMUNITIES

The intent of including the information noted above is to demonstrate that positive and useful efforts exist and can be built upon, that there is fertile ground to improve the coordination and collaboration that Tribal leaders are seeking, and that opportunities exist that can enhance behavioral health-related efforts by working together.

The most important aspect of the TBHA is that it was identified through discussions with Tribal leaders, tribal administrators, and Tribal members. It is important to note that:

- The TBHA is not an exact map but an initial step toward driving action in the same direction and along a common path. It is organized around five elements that were deemed to be foundational for designing an agenda that holds significance for Tribal communities. The foundational elements organically coalesced from conversations with Tribal leaders around their concerns with the state of behavioral health in Indian Country. Through the various meetings, discussions, and input opportunities that contributed to building this blueprint, the five foundational elements were affirmed and reaffirmed.
- The priorities that follow are a reflection of Tribal views and areas of importance through the Tribal perspective. It is significant to note that during conversations and input sessions many of the comments were not framed in terms of quantitative actions but rather in terms of the conditions that are necessary for positive emotional health and well-being to exist. As questions were posed, Tribal leaders and representatives used their cultural knowledge and experience as reference points for their comments. The framing and essence of Tribal input were consistent across discussions. The points of view shared were not optional but rather essential to a new state of collaboration among Tribal nations, Federal departments and agencies, and other interested parties – a state in which all parties commit to "working differently" together for the benefit of Tribal communities. This document honors and attempts to share input in the context in which they were given.
- Following an examination of the historical and current contexts that frame the state of behavioral health for American Indians and Alaska Natives today, the breadth and essence of Tribal input, and discussions around existing Federal programs and strategic directions, priorities for working collaboratively on a range of opportunities were developed. The opportunities extend beyond Tribes and Federal agencies to state and local entities and other potential collaborators.

The foundational elements, priority areas, and strategies section begins on page 47.

CONSIDERATIONS FOR COLLABORATION

TRIBAL, FEDERAL, AND STATE GOVERNMENT RELATIONSHIPS

Very few of the challenges cited in this document can be successfully addressed without collaborative efforts on the part of tribes and other stakeholders – most notably Federal and state governments. Tribes are sovereign entities with distinct governing structures and authorities. However, Federal and state governments bring a wealth of resources from which tribes can and do benefit. Although there are actions that tribes undertake on their own, there are others where it is mutually beneficial to collaborate with other governments. The TBHA serves as a platform for engagement and a reference point for developing and improving governmental relationships and efforts that benefit American Indians and Alaska Natives.

ALIGNMENT OF LOCAL AND NATIONAL EFFORTS

Through a process of stakeholder engagement, the priority areas within the TBHA were created to reflect the current reality of behavioral health in Indian Country. Tribes and Tribal organizations and Federal departments and agencies had opportunities to provide input. The priority areas were validated through extensive conversations and represent a unity of thought that supports the alignment of local and national efforts under common themes. Tribal, Federal, state, and local governments, as well as other stakeholders, can begin the process of examining their own efforts, identifying where those efforts connect and align to the priorities areas in the TBHA and determining how they might contribute to furthering them.

The process of alignment helps ensure that resources are allocated and spent most effectively, efforts target priority issues, communication is open, and collaboration is fruitful. These activities could lead to more informed development of programs that more effectively allow tribes to respond in a manner that meets the unique needs of their communities. The activities also could lead to expansion of opportunities within existing programs that allow tribes to work in new areas, the inclusion of tribes or urban Indian health programs in funding streams that did not previously reach them, and flexibility to ensure that the programs allow for the incorporation of traditional ways as described in the American Indian and Alaska Native Cultural Wisdom Declaration in this document. Finally, these opportunities allow for growth of thought that tribes not only use evidence-based practices along with traditional practices but also develop practices that have evidence and can inform the work of other communities. There are opportunities of mutual benefit, and those benefits are bidirectional.

CREATION AND SUPPORT OF NEW EFFORTS

The priority areas contained in the TBHA can help a tribe, urban Indian health program, other governments, and other stakeholders design new program efforts or activities that carry out the recommendations through a new and innovative method. The priority areas can assist funders create or strengthen existing programs or initiatives, whereas tribes and urban Indian health programs can do the same at the local or area level. The priority areas and strategies lend themselves to incorporation into funding opportunity announcements, framing scopes of work, and/or joint development of initiatives and programs.

CROSS-CUTTING CONSIDERATIONS

Throughout the input-gathering sessions and TBHA development discussions, several considerations for improving behavioral health arose that cut across multiple foundational elements. These considerations related to actions that support recognition of youth, identity, culture, self-sufficiency, data, and Tribal leadership. To maximize collaborative work across the foundational elements, the cross-cutting topics are defined as follows.

YOUTH

American Indian and Alaska Native culture places importance on honoring youth and building strong foundations for future generations. Native youth hold an important role in the future of tribes; however, they are significantly and negatively affected by poverty, substance use disorder, depression, and suicide and are at high risk for other behavioral health challenges. Healthy youth lead to healthy adults and healthy communities. Across foundational elements, youth were identified as an important part of the solution for issues they face as well as those faced by their peers, families, and communities. Behavioral health planning should incorporate the voices of youth and engage them in developing and implementing activities.

IDENTITY

American Indians and Alaska Natives connect their political identity with varying aspects of cultural, geographic, Tribal, familial, and social frameworks – creating a unique identity framework that is unique not only to American Indian and Alaska Native groups but also to American Indian and Alaska Native individuals. Understanding the sources of identity, honoring them, and embracing them can be a significant source of communal and individual strength that can be harnessed to combat behavioral health challenges. Behavioral health professionals who are actively working with American Indians and Alaska Natives can incorporate identity exploration into their treatment plans; community action plans can celebrate communal identities; education can take place to ensure that external collaborators, entities, and funders understand the nature of American Indian and Alaska Native identity; and, traditional practitioners can work with clinicians on how best to honor the identities of the people they serve.

CULTURE

Culture is the root of American Indian and Alaska Native identities – culture incorporates aspects of living, interpersonal and communal relationships, communication, worldviews, traditional customs, and spirituality. The uniqueness of Tribal cultures as well as their commonalities is a source of strength. Although each American Indian and Alaska Native tribe is unique, there are commonalities that tribes share, including valuing traditional practices, honoring elders, respecting nature, and emphasizing clan/community importance. American Indian and Alaska Native communities also have a Native language that serves to connect them to their culture and Tribal identities as well as create a strong cultural bond with other Indigenous communities. These commonalities affect the manner in which tribes conduct themselves, including in health care delivery and behavioral health program design and implementation.

Revitalization of American Indian and Alaska Native languages is essential to continuing culture and strengthening self-determination. Research has shown that use of languages builds identity and assists communities in moving toward social cohesion and self-sufficiency. Language and culture foster higher educational outcomes by Native youth as a result of lower levels of depression, increased academic achievement, and strengthened problem-solving skills.[191] Furthermore, American Indian and Alaska Native values and traditions are embedded in language, and there is growing evidence that language and culture act as protective factors against suicide and suicidal ideation, substance use disorders, and other risky behaviors. Languages are among the most critical and meaningful culturally and linguistically based tools to not just survive, but to thrive.

In 2008, Canadian researchers could find only one article that examined the link between Indigenous language and health. The findings were significant: Bands with higher levels of language knowledge (as measured by a majority of its members having conversational-level abilities) had fewer suicides than those with lower levels. In fact, the rates of suicide in the bands with high language knowledge levels were "well below the provincial averages for both Aboriginal and non-Aboriginal youth." When the language knowledge factor was added to six other measures, "the presence of the language factor made a drastic difference in suicide rates." In all cases but one, the suicide rate dropped to zero when the language factor was added.[192]

Tribal consultation and listening sessions held by HHS indicate that investments in Native language programs are critical to Tribal communities. As educational institutions recognize that Native culture and language are inherent strengths, the self-worth and optimism of Native youth increase. It is by going back to traditional, ancestral, Indigenous ways of knowing based in culturally and linguistically specific values and norms that American Indian and Alaska Native communities will thrive on their own terms.

INDIVIDUAL SELF-SUFFICIENCY

Tribes and Tribal members are autonomous – they have the capacity to act independently on their own behalf. While tribes know best what works and does not work for their communities, Tribal members also have the ability to make individual decisions. At the individual level, self-sufficiency encompasses the full development of individuals – spiritually, mentally, physically, educationally, and economically among other ways – in a manner that contributes to their success in life. The intent is for one to have the capacity and initiative to take care of self and ultimately contribute to the well-being of their families and communities. The value is in being able to take care of self in order to effectively contribute to the lives of others. Individual self-sufficiency contributes to Tribal self-sufficiency and the responsibilities of sovereign nations to their people. Tribal representatives who contributed to building the TBHA believe that opportunities should exist across foundational elements that contribute to the ability of Tribal members and tribes to be self-sufficient. This could include availability, accessibility, and/or oversight of education and training opportunities; access to Native foods; access to prevention and treatment resources to address unique behavioral health challenges that exist in communities; referral networks across systems that support well-being; and law enforcement agreements, among others.

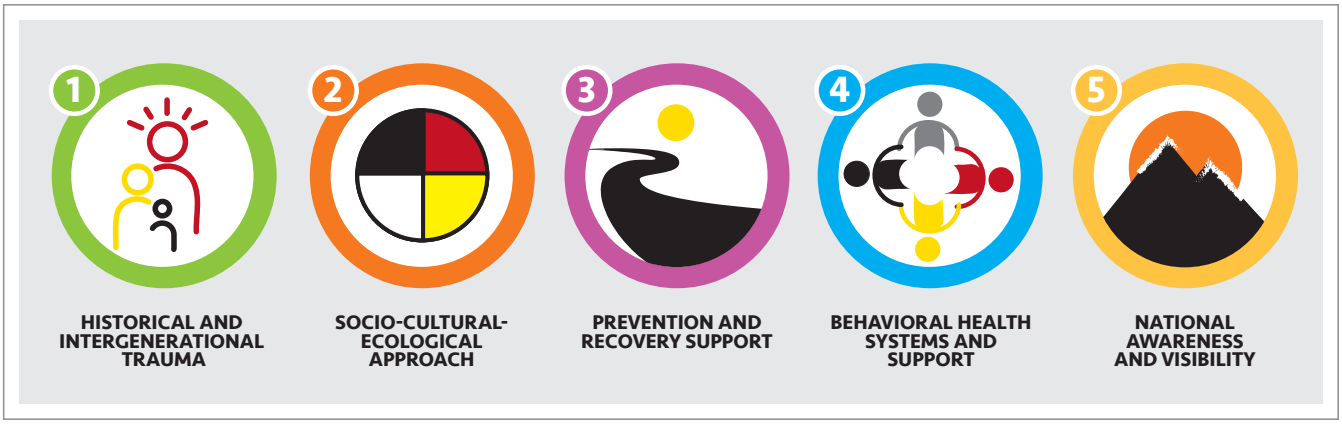
DATA

The problems of accuracy and access to viable data have long impacted American Indian and Alaska Native communities. Small sample sizes make it difficult to capture accurate data, and the same small sample sizes make sharing data even more tenuous for fear of violating confidentiality. Frequently data available to tribes is significantly outdated, requiring them to use data sets that may not reflect the reality within their community. And, all too often, American Indians and Alaska Natives are not a distinct group captured within larger data sets. Without access to timely and accurate data, communities are unable to capture their true needs, thereby inhibiting effective community-based planning and improvement of outcomes.

As a cross-cutting consideration, improving data accuracy, availability, and access offers real opportunities to improve definitions for data collection; strengthen Tribal data collection systems; provide capacity building for tribes and partners on how to collect and manage data that is tribally owned; interpret and use data to improve systems and programs; and create systems that allow partners to benefit from available data. Methodologies used in national and other non-tribal data collection systems should be assessed in order to more accurately include American Indian and Alaska Native populations in urban areas, counties, and states. These opportunities should be leveraged within strategies that support foundational elements and their accompanying priority areas and strategies.

TRIBAL LEADERSHIP

Tribal leaders care deeply for their communities and hold significant responsibility for the welfare of their people. Their leadership is critical in helping empower



communities and support readiness to change. They also have the authority and communal support to take action and can serve as drivers of meaningful community change. To be most effective on behavioral health matters, Tribal leaders must be informed about problems in their communities; lead community-based dialogs to hear from their people about behavioral health and factors that influence wellness; work with their Tribal councils and with a range of Federal departments and agencies to address prevention as well as systems, facilities, and service needs; and seek, identify, and/or champion funding and programs that most effectively support behavioral health needs.

Throughout the input received for developing the TBHA, Tribal leaders and tribal representatives conveyed that Tribal leaders need to "own" the behavioral health challenges facing their communities in order to assume true leadership on the issue. Tribal leaders viewed as being the most effective on behavioral health were identified as champions who were informed and took a visible role in driving solutions.

> ***"We continue to address the impacts of alcohol and drugs, youth suicides, domestic violence and the list continues. However, now is the time to address the source of these symptoms – historical and intergenerational trauma."***
>
> *– Tribal leader, White House Tribal Nations Conference, 2014*

Improving the behavioral health of culturally, geographically, and socioeconomically diverse populations is a complex undertaking that requires a multipronged approach. There is no single strategy that will accomplish this task; there are interwoven factors and systems that may each require intense examination, deconstruction, and retooling. Individual behavioral health risk unfolds within the social settings of families, peer networks, schools, communities, and service systems and within the cultural and historical contexts of the tribe.[193] Health care systems are needed that provide new perspectives on integrating treatment for mental and substance use disorders with holistic well-being, including family, community, socioeconomic, and social supports.[194] Strategies need to be developed to effect system- and policy-level changes that reduce barriers to high-quality care and promote the well-being of American Indian and Alaska Native youth, families, and communities.[195]

FOUNDATIONAL ELEMENTS, PRIORITY AREAS, AND STRATEGIES

The foundational elements of the Tribal Behavioral Health Agenda were the first product of the many discussions held with Tribal leaders, Tribal administrators, and tribal representatives regarding the factors contributing to or exacerbating behavioral health challenges in Indian Country. Each foundational element includes priority areas that were gleaned from targeted conversations about the most pressing concerns. The priority areas contain strategies based on analysis of responses to questions related to desired outcomes, healthy communities, and stronger systems. What follows are the results of engagement and investigation into the state of behavioral health, prevalent attitudes regarding behavioral health, predominant barriers and challenges at the systems and community levels, and insights into potential solutions.

FOUNDATIONAL ELEMENT 1:

Historical and Intergenerational Trauma (HIT)

Dr. Maria Yellow Horse Brave Heart describes historical trauma as the "cumulative emotional and psychological wounding across generations, including the lifespan, which emanates from massive group trauma"[196] and includes the impact of chronic stress and trauma that negatively affect health. These impacts are magnified when entire communities experience and reexperience past and present trauma.

It is important to understand historical and intergenerational trauma from a variety of perspectives. First, understanding the sources of the trauma is important in creating a common understanding of how the past can contribute to the present. Second, understanding and learning how to take that information and openly discuss it are important steps. American Indian and Alaska Native people may not seek to discuss traumatic events or how they manifest in their daily lives for fear of giving the trauma power. It is vital to lay out the issues in such a way that Tribal members, allies, and other stakeholders (including Federal and state governmental entities) can understand and thus meaningfully engage in a discussion of healing.

Discussions regarding trauma should not be limited to adult Tribal members. Youth also experience intergenerational trauma but may not have the skills or language to conceptualize or talk about it in the context of modern-day pressures and situations. The purpose of discovering, uncovering, and talking about historical and intergenerational trauma is to support healing. The intent of Foundational Element 1 is not necessarily to further assess historical trauma but rather to support the development of priorities and evidence- and practice-based actions to support healing for Tribal members.

Healing practices should acknowledge the root causes of intergenerational and other types of trauma (i.e., genocidal policies, forced relocations, etc.). Trauma that is directly experienced in the present compounds issues and reinforces the sense of hopelessness. Resources and community norms need to actively support the prevention of modern-day trauma and incorporate strategies to address historical and intergenerational trauma as a real and contributing factor to contemporary issues.

Federal Support for Addressing Trauma

A review of selected Federal strategic plans and documents identified a number of existing goals and recommendations focused on addressing trauma (see Appendix 3. Selected List of Federal Strategic Plans and Documents: Correlations With the National Tribal Behavioral Health Agenda). These plans and documents either cut across all populations or specifically focus on American Indians and Alaska Natives. For example, as part of its Strategic Plan "Leading Change 2.0: Advancing the Behavioral Health of the Nation," SAMHSA established trauma and justice as one of its six priorities; these priorities are linked to SAMHSA's policy, program, and financial planning. An objective within the Trauma and Justice Strategic Initiative focuses on integrating an understanding of trauma and strategies for implementing trauma-informed approaches across SAMHSA, interested Federal agencies, and other public service sectors. Similarly, a strategic initiative in ACF's Strategic Plan promotes the use of evidence-based and trauma-informed practices that effectively address the needs of children and families and encourage achievement of timely permanency for children in the child welfare system.

Recommendations in the Attorney General's Advisory Committee on American Indian/Alaska Native Children Exposed to Violence: Ending Violence so Children Can Thrive report[197] promote Tribal-state collaborations to meet the needs of children who have been exposed to violence. The recommendations also support training for American Indian and Alaska Native communities on the needs of children exposed to violence and for Federal employees who are assigned to work on issues pertaining to American Indian and Alaska Native communities to obtain training within the first 60 days of their job assignment. Additional recommendations focus on collaborations with organizations that specialize in treatment and services for traumatized children, the establishment of safe places where children exposed to violence can obtain services, and the promotion of youth afterschool programs that are culturally based and trauma informed.

Federal efforts such as SAMHSA's Tribal Behavioral Health Grant program focus not only on preventing and reducing suicidal behavior and substance use and promoting mental health but also on addressing the impact of trauma. Tribes and Tribal organizations can propose activities that are aligned with the particular needs of their communities, such as implementing community events to address historical and intergenerational trauma, beginning collective conversations about trauma, and building consensus on solutions. The IHS, through its Telebehavioral Health Center of Excellence, provides a range of behavioral health services, technical assistance, and training via electronic mechanisms on current and pressing behavioral health issues, including historical and intergenerational trauma. The NIH funded ongoing research study "Historical Trauma Informed Clinical Intervention Research and Practice," which could further Tribal efforts to address historical and intergenerational trauma in Tribal communities.

These and other Federal and Tribal strategic efforts and programs provide existing pathways on which to build or expand strategies that more effectively address healing from trauma.

Priority Areas and Strategies

Priority areas emerged from tribal input that focus on creating viable and appropriate support mechanisms, promoting community connectedness, and breaking the cycle of trauma. The following three priority areas reflect the views from the conversations. Following each priority area below are recommended strategies for addressing them.

HIT1 – Support Systems

At the core of this priority area is the importance of ensuring that families who have also been affected by traumatic events receive appropriate support. The intent is that all members of a family receive the support required for individuals and the collective to heal. Without support mechanisms for all family members, strategies to assist individual family members may fail. Incorporation of supports for the family will require program flexibility, collaboration, and commitment. It is important that tribes be informed of the resources available to them and, even more importantly, that tribes are comfortable with the competency and scope of the resources. Recommended strategies include:

- **HIT1.1:** Actively inform communities about the forms of trauma and their manifestations as a means for enhancing the potential for family engagement in services.
- **HIT1.2:** Incorporate into Federal, Tribal, and other programs opportunities for engaging family members who live with trauma as part of funded activities to ensure that they have access to support mechanisms.
- **HIT1.3:** Allow tribes, within existing programs and new funding streams, the flexibility to develop, tailor, and/or implement support mechanisms that best address their local and specific manifestations of trauma.
- **HIT1.4:** Incorporate opportunities to address unresolved grief as a root cause of behavioral health challenges and a core component in positive healing within programs that focus on Tribal communities.
- **HIT1.5:** Strengthen support systems across health, behavioral health, education, child welfare, and justice services programming to ensure continuity and availability of support for family members who connect through different systems.

HIT2 – Community Connectedness

The literature shows that an individual's sense of his or her own belonging, and connection to the communities he or she lives in, is a strong protective factor against many behavioral health issues, including suicide, depression, and substance use. Fostering connectedness with their communities includes expanding inherent strengths within a person and a community, strengths such as pride, self-esteem, community values, tradition, culture, and local resources. Recommended strategies include:

- **HIT2.1:** Expand opportunities for tribes to incorporate Native language learning and development as a means for strengthening pride, self-esteem, identity, and other contributions to community connectedness.
- **HIT2.2:** Provide support for creating new or maximizing existing healthy social structures and social supports through schools and other local settings that permit community members to engage and be validated as valuable members of the community.
- **HIT2.3:** Support Gathering of Native Americans (GONA) events to support community healing from historical trauma and enhance local prevention capacity through meaningful activities that incorporate healthy traditions; focus on a holistic approach to wellness; empower community members; and provide a safe place to share, heal, and plan for action.

PROJECT MAKING MEDICINE

This project is a culturally adapted, evidence-based training program for treating child physical and sexual abuse whose overarching goal is to improve clinician capability to provide early identification and a culturally appropriate response to victims of familial violence and abuse, particularly women and children, in American Indian and Alaska Native communities.

HIT3 – Breaking the Cycle

One of the most insidious aspects of historical trauma is its heritability. It is passed down through families and communities – most often unknowingly – exposing future generations to centuries-old sorrow and trauma. Opportunities to intervene in this process are often overlooked or not identified, and so the cycle continues. An important way to actively promote healing is to break this cycle and interrupt the passing down of messages that contribute to trauma. Trauma should be proactively addressed in informed ways by the appropriate tribal (e.g., family members, teachers, leaders, traditional practitioners, behavioral health professionals) and non-tribal parties. Recommended strategies include:

- **HIT3.1:** Align Tribal, Federal, and other programs that support actions to address trauma and prevent retraumatization as a means for supporting trauma-informed services that are continuous across systems.
- **HIT3.2:** Integrate authentic cultural interventions and culturally tailored evidence-based practices into existing Tribal programs as a means for reestablishing Tribal spiritual conditions of physical, mental, and spiritual health.
- **HIT3.3:** Review and modify Tribal, Federal, state, and other programs to recognize and address the impacts of adverse childhood experiences among American Indian and Alaska Native populations.
- **HIT3.4:** Widely diffuse strategies, in concert with established support mechanisms, across Tribal communities to encourage families to talk in safe ways about their own identities and experiences with trauma to begin the process of healing.
- **HIT3.5:** Develop a research agenda on current, historical and intergenerational trauma to aid building knowledge in areas that require further investigation.
- **HIT3.6:** Use existing workforce development/learning centers to intensify education for health, behavioral health, and other professionals about historical and intergenerational trauma and support efforts to more effectively address trauma in clinical and professional settings.

Who can help advance the historical and intergenerational trauma priorities?

CHART 1:

ADVANCING HISTORICAL AND INTERGENERATIONAL TRAUMA PRIORITIES	OPPORTUNITIES					
	Individual	Family	Community	Tribal Government	State Government	Federal Government
HIT1.1: Actively inform communities about the forms of trauma and their manifestations as a means for enhancing the potential for family engagement in services.	✓	✓	✓	✓	✓	✓
HIT1.2: Incorporate into Federal, Tribal, and other programs opportunities for engaging family members who live with trauma as part of funded activities to ensure that they have access to support mechanisms.	✓	✓	✓	✓	✓	✓
HIT1.3: Allow tribes, within existing programs and new funding streams, the flexibility to develop, tailor, and/or implement support mechanisms that best address their local and specific manifestations of trauma.			✓	✓	✓	✓
HIT1.4: Incorporate opportunities to address unresolved grief as a root cause of behavioral health challenges and a core component in positive healing within programs that focus on Tribal communities.			✓	✓	✓	✓
HIT1.5: Strengthen support systems across health, behavioral health, education, child welfare, and justice services programming to ensure continuity and availability of support for family members who connect through different systems.				✓	✓	✓
HIT2.1: Expand opportunities for tribes to incorporate Native language learning and development as a means for strengthening pride, self-esteem, identity, and other contributions to community connectedness.				✓	✓	✓
HIT2.2: Provide support for creating new or maximizing existing healthy social structures and social supports through schools and other local settings that permit community members to engage and be validated as valuable members of the community.	✓	✓	✓	✓	✓	✓
HIT2.3: Support Gathering of Native Americans (GONA) events to support community healing from historical trauma and enhance local prevention capacity through meaningful activities that incorporate healthy traditions; focus on a holistic approach to wellness; empower community members; and provide a safe place to share, heal, and plan for action.	✓	✓	✓	✓	✓	✓
HIT3.1: Align Tribal, Federal, and other programs that support actions to address trauma and prevent retraumatization as a means for supporting trauma-informed services that are continuous across systems.				✓	✓	✓
HIT3.2: Integrate authentic cultural interventions and culturally tailored evidence-based practices into existing Tribal programs as a means for reestablishing Tribal spiritual conditions of physical, mental, and spiritual health.	✓	✓	✓	✓		
HIT3.3: Review and modify Tribal, Federal, state, and other programs to recognize and address the impacts of adverse childhood experiences among American Indian and Alaska Native populations.				✓	✓	✓
HIT3.4: Widely diffuse strategies, in concert with established support mechanisms, across Tribal communities to encourage families to talk in safe ways about their own identities and experiences with trauma to begin the process of healing.	✓	✓	✓	✓	✓	✓
HIT3.5: Develop a research agenda on historical and intergenerational trauma to aid building knowledge in areas that require further investigation.				✓	✓	✓
HIT3.6: Use existing workforce development/learning centers to intensify education for health, behavioral health, and other professionals about historical and intergenerational trauma and support efforts to more effectively address trauma in clinical and professional settings.			✓	✓	✓	✓

FOUNDATIONAL ELEMENT 2:

Socio-cultural-ecological (SCE) Approach

Behavioral health challenges evolve in a multivariate environment that extends well beyond the individual. A socio-cultural-ecological approach aims to understand and address the problems recognized and to work within the construct of the social determinants of health. An individual exists within intersecting spheres of influence that include peers and social networks, families, communities, governing structures, economic systems and circumstances, and the even broader and often intangible influences of culture and history. These influencing factors impact an individual's attitudes about what is acceptable and how to behave and thus help shape the norms that create and solidify an individual's worldview. A socio-cultural-ecological approach elevates cultural preservation and revitalization as a key element of mental health for communities.

Many factors shape how people conceptualize health, health services, and what is considered healthy. These factors are even more complicated in American Indian and Alaska Native communities where traditional spheres of influence are often in conflict with Western approaches. For example, a Western governance structure communicates a different style of leadership and engagement than a more traditional and historical Native approach. These powerful variables contribute to how a community responds to challenges and how resources are structured to address such challenges.

The intent of Foundational Element 2 is to both begin to understand the larger context and pressures within which American Indian and Alaska Native behavioral health issues are rooted and guide interventions and efforts to address root and base causes of these issues. Solutions to behavioral health challenges must target factors that contribute to the problem and cause it to proliferate. Approaches that are part of the socio-cultural-ecological model will bring in collaborators that have expertise or influence over a variety of factors that may support development of viable solutions – these factors include environment, justice, financial systems, education, health, housing, labor, and transportation.

Whereas a socio-cultural-ecological approach could focus on a variety of factors, including those identified above, Tribal leaders, communities, and programs also can focus on factors contributing to sustaining environmental resources, reliable infrastructure, and healthy families and kinship.

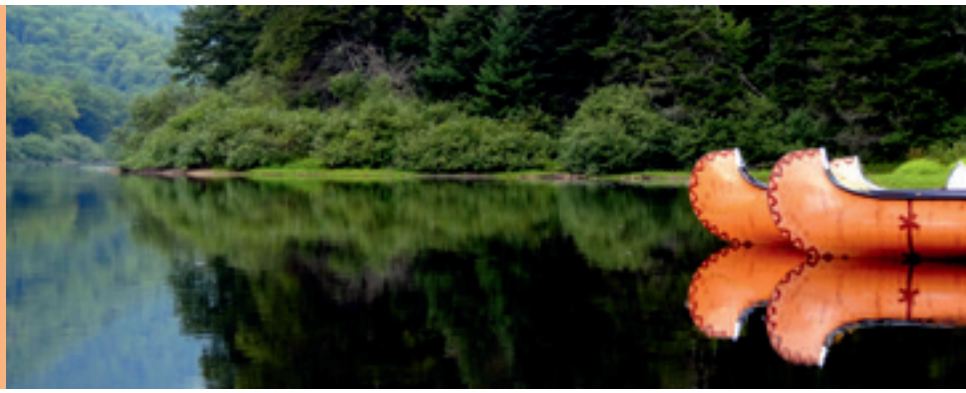
Federal Support for Addressing Socio-cultural-ecological Factors

Federal agencies are supporting wide-ranging efforts to improve physical health and behavioral health. For example, NIH is conducting the ongoing study "Ojibwe Pathways" through the high school years. The study will use prospective data to investigate culturally specific protective factors that exist within the Ojibwe culture that may prevent, delay, or reduce the consequences of early-onset substance misuse and transition to substance use disorder. It will also assess the risk factors associated with individual characteristics and the social contexts of Ojibwe children during their high school years.

The BIA, through its Housing Improvement Program, provides grants for cost-effective services to repair, renovate, or replace existing housing and provide new housing for eligible members of federally recognized Indian tribes. This program is carried out in collaboration with the U.S. Department of Housing and Urban Development and the U.S. Department of Agriculture.

The IHS's Great Plains Area and DOI's Bureau of Indian Education (BIE) established a formal partnership to deliver behavioral health services in BIE-operated schools. The IHS will evaluate this partnership as a potential national model of community- and school-based services.

The SSA, through its Video Service Delivery (VSD), has also developed a process that provides immediate services to tribes whose SSA field offices may be located great distances from reservations. VSD is a great resource for tribes such as the Pine Ridge Indian reservation in South Dakota, who experienced a 300% increase in claims. Through VSD, the SSA is able to process numerous services that are important to obtaining or maintaining information about services such as applying for a replacement Social Security Number card or changing an address.



The CDC, through its Good Health and Wellness in Indian Country program, uses a model to directly fund tribes to prevent heart disease, diabetes, stroke, and associated risk factors in American Indian tribes and Alaska Native villages through a holistic approach to population health and wellness. Funded tribes use effective community-chosen and culturally adapted public health interventions using a combination of policy and environmental approaches, community clinical linkages, and health system interventions. This model also promotes the leadership of Tribal organizations and use of culturally adapted evidence-based interventions. Examples of program priorities include improvement in nutrition and physical activity and an increase in health literacy.

Priority Areas and Strategies

Priorities areas emerged from tribal input that focus on sustaining environmental resources, ensuring reliable infrastructure, and supporting healthy families and kinship. Following each priority area below are recommended strategies for addressing them.

SCE1 – Sustaining Environmental Resources

One commonality tribes share is a strong connection to nature and the environment; nature is highly revered and treated with respect. The connection is not only spiritual but also a way of life that includes nature as a source of traditional foods and medicine. Tribes have experienced devastation that has endangered nature and hope to protect and preserve their environment. Protecting the environment and tribal lands is directly related to tribes' sovereign interest in protecting natural resources and treaty rights. Recommendations include:

- **SCE1.1:** Proactively advance collaborations among Tribal, Federal, and state programs to protect environmental resources as a vital part of the spiritual connection and traditional lifestyle.
- **SCE1.2:** Incorporate actions across Tribal, Federal, and state programs that improve access to safe and healthy traditional foods.

SCE2 – Reliable Infrastructure

Tribes and Tribal communities face many challenges when it comes to infrastructure. Unemployment rates throughout Indian Country are high, and housing shortages affect Tribal members. The lack of adequate housing not only poses obvious challenges for Tribal members but also impacts the ability to attract and support a critically needed health services workforce. Recommended strategies include:

- **SCE2.1:** Strengthen educational capacity of schools and access to education resources.
- **SCE2.2:** Collaborate with state and Federal agencies on creative opportunities for addressing the determinants of health, including opportunities to increase housing stock, facilitate transportation needs, and improve job readiness.
- **SCE2.3:** Improve collaboration during the planning of new tribal housing to ensure water and waste infrastructure needs are considered.
- **SCE2.4:** Strengthen tribal capacity to effectively manage water programs.

SCE3 – Healthy Families and Kinship

Similar to community connectedness, family structures within Indian Country are vital sources of strength. However, family structures are becoming more fragmented, with many youth lacking strong parental figures in their lives. Strong family structures are important in helping youth grow into healthy and resilient adults. Elders are the gatekeepers of knowledge and tradition within Tribal communities, and tribes have suggested engaging elders in a more meaningful way by strengthening their connection with youth. Recommended strategies include:

- **SCE3.1:** Support broader efforts to strengthen families as integral prevention and invention mechanisms and develop family-driven strategies for reinforcement.
- **SCE3.2:** Collaborate across local, Tribal, state, Federal, and private and non-profit organizations to leverage opportunities to create safe and nurturing environments for youth.
- **SCE3.3:** Expand collaboration across education, health, and human service systems that engage, support, and protect elders.

Who can help advance socio-cultural-ecological priorities?

CHART 2:

ADVANCING SOCIO-CULTURAL-ECOLOGICAL PRIORITIES

	OPPORTUNITIES					
	Individual	Family	Community	Tribal Government	State Government	Federal Government
SCE1.1: Proactively advance collaborations among Tribal, Federal, and state programs to protect environmental resources as a vital part of the spiritual connection and traditional lifestyle.	✓	✓	✓	✓	✓	✓
SCE1.2: Incorporate actions across Tribal, Federal, and state programs that improve access to safe and healthy traditional foods.			✓	✓	✓	✓
SCE2.1: Strengthen educational capacity of schools and access to education resources.				✓	✓	✓
SCE2.2: Collaborate with state and Federal agencies on creative opportunities for addressing the determinants of health, including opportunities to increase housing stock, facilitate transportation needs, and improve job readiness.	✓	✓	✓	✓		
SCE2.3: Improve coordination during the planning of new tribal housing to ensure water and waste infrastructure needs are considered.			✓	✓		✓
SCE2.4: Strengthen tribal capacity to effectively manage water programs.			✓	✓	✓	✓
SCE3.1: Support broader efforts to strengthen families as integral prevention and invention mechanisms and develop family-driven strategies for reinforcement.	✓	✓	✓	✓	✓	✓
SCE3.2: Collaborate across local, Tribal, state, Federal, and private entities to leverage opportunities to create safe and nurturing environments for youth.	✓	✓	✓	✓	✓	✓
SCE3.3: Expand collaboration across education, health, and human service systems that engage, support, and protect elders.	✓	✓	✓	✓	✓	✓

FOUNDATIONAL ELEMENT 3:

Prevention and Recovery (PR) Support

Strong public health delivery models emphasize early identification of community health issues to prevent the deterioration of health and wellness. Similarly, following an intervention, services should be available to provide ongoing, comprehensive support for recovery and prevention. Existing systems must be strengthened to assess for the availability of critical services, gaps in services, and opportunities for improvement to meet community needs.

Federal Support for Addressing Prevention and Recovery Support

A number of Federal strategic plans address prevention and recovery efforts. For example, IHS, through its American Indian/Alaska Native National Behavioral Health Strategic Plan, is working to launch a systemwide collaboration between those working in child abuse/neglect prevention and those working in behavioral health to coordinate services for the whole family. Additional IHS strategies support community-specific planning, readiness, and mobilization around the prevention of suicide, violence, and substance misuse.

SAMHSA, through "Leading Change 2.0: Advancing the Behavioral Health of the Nation," is working to enhance cooperation and coordination among Federal and non-Federal organizations to prevent and reduce underage drinking and to promote recovery-oriented service systems that include coordinated clinical treatment and recovery support. Recommendations developed through the Attorney General's Advisory Committee on American Indian/Alaska Native Children Exposed to Violence "Ending Violence so Children Can Thrive" report[198] also support access to culturally appropriate behavioral health and substance use prevention and treatment.

The noted Federal strategic plans and report and others support critical programming. IHS's Methamphetamine and Suicide Prevention Initiative (MSPI) expands community-level access to effective methamphetamine and/or suicide prevention and treatment programs. MSPI also enhances evidence- and practice-based methamphetamine and suicide prevention and treatment programs and community mobilization programs. The IHS Domestic Violence Prevention Initiative (DVPI) promotes the development of evidence- and practice-based models that represent culturally appropriate prevention and treatment approaches to domestic violence and sexual assault from a community-driven context. The DVPI expands outreach and increases awareness by funding programs that provide outreach, victim advocacy, intervention, policy development, community response teams, and community and school education programs.

The BIA's Domestic Violence Prevention Program focuses on developing strategies to expand family services related to domestic violence, improve teamwork between law enforcement and social services to more rapidly address instances of domestic and family violence, and improve the coordination of services with other domestic and family violence partners in Indian Country. This program addresses the unmet needs of Native communities with high rates of domestic and family violence and high incidences of child abuse and neglect. The BIA collaborates on this program with DOJ and HHS.

VA established the national Opioid Safety Initiative (OSI) to reduce unsafe opioid pain medicine prescribing. The purpose of the OSI is to prevent opioid overdose and opioid use disorder. This multipronged approach includes provider and patient education about the risks and benefits of opioid pain medicines for chronic non-cancer pain, increasing access to more effective and safe stepped care strategies for chronic pain management, co-prescribing of naloxone rescue kits for those at-risk of overdose, and, when indicated, providing medication assisted treatment

for opioid use disorder using buprenorphine/naloxone, methadone administered through an opioid treatment program, or extended-release injectable naltrexone. DOJ launched its Coordinated Tribal Assistance Solicitation (CTAS) in FY 2010 in direct response to concerns raised by tribal leaders about the Department's grant process that did not provide the flexibility tribes needed to address their criminal justice and public safety needs. DOJ designed this comprehensive approach to save time and resources and allow tribes and DOJ to gain a better understanding of the tribes' overall public safety needs.

Under CTAS, the Bureau of Justice Assistance offers justice systems and alcohol and substance misuse funding. Tribes are able to develop, enhance, and continue tribal justice systems, including law enforcement, pretrial services, risk and needs assessment development and implementation, diversion programming, tribal court services, detention programming, community corrections, re-entry planning and programming, justice system infrastructure enhancement, and justice system information sharing.

Tribes can also respond to and prevent alcohol- and substance use-related crimes, including alcohol and substance use prevention, healing to wellness courts, intervention, or treatment. They are also able to: (a) develop, implement, and enhance substance use prevention and treatment programs, including those that prevent and address the needs of drug-endangered children; (b) implement enhanced authorities and provisions under the Tribal Law and Order Act and the Violence Against Women Reauthorization Act of 2013; and (c) engage in comprehensive strategic planning to improve tribal justice and community safety as it relates to tribal courts and alcohol and substance use.

DOJ incorporated the Juvenile Healing to Wellness Courts program into the CTAS in FY 2015 to enhance the capacity of tribal courts to respond to the alcohol and substance use-related issues of youth under the age of 21.

Through the Garrett Lee Smith (GLS) State/Tribal Suicide Prevention Program, SAMHSA has funded 49 tribes, Tribal organizations, and urban Indian organizations to carry out youth suicide prevention projects. The purpose of the GLS Program is to support states and tribes in developing and implementing statewide or Tribal youth suicide prevention and early intervention strategies. The program strongly encourages collaboration among youth-serving institutions and agencies and includes schools, educational institutions, juvenile justice systems, foster care systems, substance use and mental health programs, and other child- and youth-supporting organizations.

SAMHSA's GLS Program cross-site evaluation found that these grants have had a lifesaving impact. Counties that implemented GLS-funded youth suicide prevention activities had lower rates of youth deaths by suicide and nonfatal suicide attempts than matched counties that did not. This was estimated to amount to 487 suicide deaths averted and 79,000 nonfatal suicide attempts averted. It is unknown whether the impact was equally distributed across states and tribes. However, the impact was stronger in rural counties. This powerful impact was present in the first year after the activities were implemented and faded in the second year, strongly suggesting the importance of embedding suicide prevention within a sustainable infrastructure in both states and tribes.[199, 200] In addition to the findings from the cross-site evaluation, local evaluations of some Tribal suicide prevention efforts have also been encouraging.

WHITE MOUNTAIN APACHE TRIBE (WMAT)

The WMAT suicide prevention program, working with the Johns Hopkins Center for American Indian Health, includes the evaluation of two culturally adapted interventions. These interventions are linked to a unique tribally mandated suicide surveillance system that identifies youth who have exhibited suicidal behavior. Preliminary results suggest a reduction in suicidal ideation for the interventions. An important element of the WMAT system is that every suicidal youth reported to the system receives rapid follow up by the Apache community workers, typically in their homes.

Lessons learned from a decade of SAMHSA-funded American Indian and Alaska Native suicide prevention efforts include:

- Suicide prevention efforts must be organized in a comprehensive way to be successful and must include all youth-serving organizations and institutions. Buy-in by the community and Tribal leadership is essential and can be facilitated by a Tribal resolution. Building organizational infrastructure from the beginning is important.
- Tribes need access to their own data to be able to plan meaningful and effective suicide prevention activities. Understanding that historical trauma affects resistance to evaluation is vital since, historically, evaluation meant that something would be taken away from a community or used without community consent. Data and evaluation should be used by the community for the community.
- Tribes should have protocols in place to guide how to respond to at-risk youth encountering any part of Tribal youth-serving systems.
- Youth with suicidal ideation or who have made a suicide attempt must receive active outreach in the community. Discharge from a hospital inpatient unit or emergency department cannot be considered sufficient to eliminate suicide risk; rather, connection with the youth needs to be maintained for a minimum of 90 days during this high-risk period.
- Trained community workers can play a vital role in suicide prevention efforts.
- Suicide clusters can have a profound, tragic, and potentially multigenerational impact on Tribal communities. Sharing learning and experiences in responding to a suicide cluster is of great significance in helping us learn how to prevent clusters from starting and how to interrupt them once they have begun.
- Health and mental health programs serving tribes would benefit from utilization of a systematic suicide prevention effort such as that encapsulated in the Zero Suicide prevention model.
- Coordinated crisis response and crisis intervention systems are critical.
- There is a need for increased family participation in suicide prevention work. Much of the federally supported work has focused on the community and youth, but there is a need to work more intensively on family involvement.

Priority Areas and Strategies

Priority areas that emerged from tribal input focus on restructuring programming to meet community needs and advance community mobilization and engagement. Following each priority area below are recommended strategies for addressing them.

PR1 – Programming That Meets Community Needs

All prevention and treatment programs are not designed to meet the diverse needs of differing communities, nor are they designed to readily incorporate traditional American Indian and Alaska Native worldviews that promote health and healing. Tribal communities must have the flexibility, support, and resources to implement prevention, treatment, and recovery programming that meet the needs of their populations. Recommendations include:

- **PR1.1:** Create and support culturally and spiritually based programming and healing that aligns with the diversity and needs of the local Tribal population and engages communities in the development of diversion and reentry programs.
- **PR1.2:** Support and coordinate reentry programming across service sectors and programming for incarcerated persons and their families, especially their children.

- **PR1.3:** Prioritize and collaborate on behavioral health-related prevention efforts as a primary strategy across education, health, behavioral health, child welfare, law enforcement, and other systems.

- **PR1.4:** Treat mental and substance use disorders as chronic conditions that require support and services across the spectrum – from prevention for individuals at all levels of risk through recovery.

- **PR1.5:** Advocate for and support comprehensive suicide prevention efforts that incorporate protocols for at-risk youth and adults, required infrastructure for supporting suicide prevention, active community outreach following discharge from the hospital or the emergency department, trained community workers, and coordinated crisis response and intervention systems.

- **PR1.6:** Support, establish, or improve data collection systems to support the collection of information on suicide prevention activities that is managed locally or in collaboration with a Tribal Epidemiology Center.

- **PR1.7:** Support suicide prevention efforts that include youth, families, and communities.

- **PR1.8:** Build and sustain supportive environments in schools.

- **PR1.9:** Support and promote Tribal Healing to Wellness Courts, Veterans Courts (or the VA Diversion Courts Peer-to-Peer Support Program), and other courts that support recovery.

PR2 – Community Mobilization and Engagement

Behavioral health is a community health issue that requires a communitywide response. Given the importance of addressing behavioral health problems in many communities, Tribal leaders should take ownership of these issues and work with their tribal community, tribal councils, Federal agencies, state agencies, regional and local partners, and other interested parties to develop an appropriate local response. Communities may need guidance from their leaders to understand their choices for response including seeking approval for technical assistance from organizations or agencies. Strategies include:

- **PR2.1:** Formulate and implement long-term, communitywide engagement and mobilization strategies that emphasize community ownership of their issues and solutions.

- **PR2.2:** Support and train community members to serve as peer counselors.

- **PR2.3:** Actively address and support the behavioral health-related programming needs of urban- and reservation-based American Indian and Alaska Native populations.

Who can help advance prevention and recovery priorities?

CHART 3:

ADVANCING PREVENTION AND RECOVERY PRIORITIES

	OPPORTUNITIES					
	Individual	Family	Community	Tribal Government	State Government	Federal Government
PR1.1: Create and support culturally and spiritually based programming and healing that aligns with the diversity and needs of the local Tribal population and engages communities in the development of diversions and reentry programs.	✓	✓	✓	✓	✓	✓
PR1.2: Support and coordinate reentry programming across service sectors and programming for incarcerated persons and their families, especially their children.	✓	✓	✓	✓	✓	✓
PR1.3: Prioritize and collaborate on behavioral health-related prevention efforts as a primary strategy across education, health, behavioral health, child welfare, law enforcement, and other systems.	✓	✓	✓	✓	✓	✓
PR1.4: Treat mental and substance use disorders as chronic conditions that require support and services across the spectrum – from prevention for individuals at all levels of risk through recovery.	✓	✓	✓	✓	✓	✓
PR1.5: Advocate for and support comprehensive suicide prevention efforts that incorporate protocols for at-risk youth and adults, required infrastructure to supporting suicide prevention, active community outreach following discharge from the hospital or the emergency department, trained community workers, and coordinated crisis response and intervention systems.	✓	✓	✓	✓	✓	✓
PR1.6: Support, establish, or improve data collection systems to support the collection of information on suicide prevention activities that is managed locally or in collaboration with a Tribal Epidemiology Center.				✓	✓	✓
PR1.7: Support suicide prevention efforts that include youth, families, and communities.	✓	✓	✓	✓	✓	✓
PR1.8: Build and sustain supportive environments in schools.	✓	✓	✓	✓	✓	✓
PR1.9: Support and promote Tribal Healing to Wellness Courts, Veterans Courts (or the VA Diversion Courts Peer-to-Peer Support Program), and other courts that support recovery.	✓	✓	✓	✓	✓	✓
PR2.1: Formulate and implement long-term, communitywide engagement and mobilization strategies that emphasize community ownership of their issues and solutions.	✓	✓	✓	✓	✓	✓
PR2.2: Support and train community members to serve as peer counselors.			✓	✓	✓	✓
PR2.3: Actively address and support the behavioral health-related programming needs of urban- and reservation-based American Indian and Alaska Native populations.	✓	✓	✓	✓	✓	✓

FOUNDATIONAL ELEMENT 4:

Behavioral Health (BH) Systems and Support

As with all systemic issues, arriving at options for improving behavioral health services is complex. An assessment of applicable systems and their interactions with the community and community members is critical to identifying challenges and realistic opportunities for identifying resources for needed services. The source of resources can vary – Tribal, Federal, state, or private – and require that tribes and other stakeholders work together to create coordinated and effective systems for American Indian and Alaska Native peoples.

Issues that impact access, quality, and availability of health, behavioral health, and related services have long been raised by Tribal leaders, community members, and other stakeholders. The literature describes concerns related to personnel shortages, limited health care resources, and lengthy travel distances to obtain services. Other issues also inhibit access to appropriate services, including lack of referrals from school, detention, court appearances, housing needs, primary care, child welfare, and other systems.

The intent of Foundational Element 4 is not only to identify challenges but also to address priorities and strategies that improve coordination, linkages, and access to high-quality behavioral health services. The strategies include examination of the available workforce, development of the existing workforce, ensuring cultural competency in the delivery of services, and potential options for improving meaningful access. In Tribal communities, geographic distances to obtain services and staffing concerns inhibit community members from seeking services, but low utilization numbers also may reflect a belief that services are not effective or in line with an individual's path for healing or inclusive of the person's worldview. The reflection of belief systems within services and as part of service delivery is also a real consideration for American Indian and Alaska Native people who live in urban areas and may receive referrals to providers who have no historical experience in working with Native peoples.

Additional service and service system considerations always include concerns related to funding – amounts, streams, allocations, and adequacy. Substantive system change cannot take place without adequate resources to create and support the desired change. In keeping with the purpose and approach of the TBHA, specific and detailed recommendations about funding have not been made. Discussions regarding the funding of programs and initiatives should be managed by the appropriate Tribal and Federal authorities.

Foundational Element 4, one of the most complex foundational elements in the TBHA, creates substantial opportunities for collaboration. Potential collaborations may involve prevention, treatment, and services, including sources of referrals, education and communication, patient navigation, advocacy services, and more. It engages the community and its leadership to positively influence attitudes, foster support for improvements, and drive actions that align with and benefit local needs.

Federal Support for Addressing Behavioral Health Services and Systems Improvement

Behavioral health issues are addressed in many existing Federal strategic plans. For example, SAMHSA and IHS, through their strategic plans, collectively have nearly 20 objectives focused on suicide prevention and skilled follow up; implementing effective clinical and professional practices and standards for assessing and treating those at risk for suicide; raising awareness about prescription drug misuse; removing financial barriers and incentivizing effective care coordination and integrated treatment delivery; supporting culture-based approaches; and training and support for behavioral health providers.

The IHS's Behavioral Health Program provides vital outpatient mental health counseling and access to dual diagnosis services, mental health crisis response and triage, case management services, community-based prevention programming, and outreach and health education activities. The IHS also operates the Alcohol and Substance Abuse Prevention Program to raise the behavioral health status of American Indian and Alaska Native communities to

the highest possible level through a comprehensive array of preventive, educational, and treatment services that are community driven and culturally competent. Tribal contracting has enabled both of these programs to transition from IHS to local community control.

The VA has established several telebehavioral clinics in IHS and Tribal health programs in Montana, Arizona, and Alaska to increase access to care closer to home. The intent is to increase access to behavioral health services for veterans in Tribal and rural communities through collaboration with local health care providers in the establishment of embedded VA telehealth clinics. The VA will explore opportunities to expand telebehavioral services to additional Tribal communities or clinics serving veterans.

SAMHSA also funds adult treatment drug courts and Tribal healing to wellness courts. Tribes funded through this program provide a coordinated, multisystem approach that combines the sanctioning power of treatment drug courts with effective substance use disorder treatment services to break the cycle of criminal behavior, alcohol and other drug misuse, and incarceration or other penalties. SAMHSA funds also are used to serve people diagnosed with a substance use disorder as their primary condition.

Workforce-related programs exist throughout the Federal Government. For example, HRSA, through its National Health Service Corps Program, seeks eligible clinicians (including mental and behavioral health professionals) to provide culturally competent, interdisciplinary primary health care services to underserved populations that reside in selected Health Professional Shortage Areas. HRSA's Regional Administrators work in collaboration with SAMHSA Regional Administrators to assess the behavioral health needs of Tribal communities and addresses identified needs by providing training and technical assistance. In addition, BIA, through its Job Placement and Training Program, funds tribes to provide training and work experience to decrease unemployment.

The NIH funded a study on evidence-based practices and substance use treatment for Native Americans. The study explored evidence-based practices to describe the factors associated with the decision to implement them in these programs, identify methods for more effective dissemination of evidence-based practices to substance use treatment programs serving American Indian and Alaska Native communities, and identify characteristics of the workforce implementing American Indian and Alaska Native substance use treatment measures.

The SSA offers a variety of benefits for Tribal members, including retirement and disability programs, Supplemental Security Income, Medicare, online account access with *mySocialSecurity*, and special programs. SSA is working to improve access and understanding of available programs such as the Medicare Extra Help Program to assist qualified beneficiaries with their Medicare Prescription drug plan costs; and, the Wounded Warriors program which offers expedited case processing for disability benefits for military service members.

The HHS Office of Minority Health's National Workforce Diversity Pipeline Program supports projects that develop innovative strategies to identify promising students in their first year of high school and provide them with a foundation to pursue successful careers in the health professions. The program seeks to address health disparities among racial and ethnic minorities by supporting networks of institutions focused on, and with demonstrated commitment and capacity to establish, pipeline programs to increase minority and disadvantaged students' awareness and pursuit of careers in health care, including behavioral health.

Priority Areas and Strategies

BH1 – Workforce Development

Tribes face staffing shortages at nearly all levels. Sometimes these shortages can mean that an individual in crisis is not able to receive immediate, adequate care. Furthermore, many tribes believe that behavioral health professionals would benefit from cultural competency training. In the face of high levels of unemployment and staffing shortages, improving the skills and practice of existing providers and addressing development of the behavioral health workforce using a "grow your own" model are highly favored. Strategies include:

- **BH1.1:** Support and develop collaboration among tribes, Tribal organizations, Tribal Colleges and Universities, (TCUs) and Federal agencies to establish local "grow your own" behavioral health education programs and provide basic training for local Tribal behavioral health aides (community workers). For areas with limited access to TCUs other forms of collaboration for supporting training should be explored.
- **BH1.2:** Establish collaborations between tribes and Addiction Technology Transfer Centers to support education, training for certification exams, and clinical supervision opportunities for behavioral health professionals working in Tribal facilities to obtain and maintain certification.
- **BH1.3:** Support the incorporation of traditional practitioners within service delivery systems and provide training on cultural and organizational competency for all employees.
- **BH1.4:** Actively pursue collaborations with the HRSA National Health Service Corps Program to recruit psychiatrists, behavioral health professionals, and other practitioners to work in Tribal facilities.

BH2 – Funding Mechanisms

Tribal behavioral health programs frequently struggle as a result of insufficient funding. Programs are frequently underfunded or funded only for a finite period. Furthermore, the requirements of some programs do not always align with other Tribal priorities, values, or traditional practices. Tribes have advocated for greater access to particular funding streams and for direct funding from Federal programs rather than through states. Strategies include:

- **BH2.1:** Assess state engagement with tribes and promote meaningful state/Tribal consultations.
- **BH2.2:** Monitor state behavioral health spending and support equitable resources and support to tribes and other entities providing services for Tribal members.
- **BH2.3:** Increase flexibility in funding requirements to tribes to support culturally based programming that meets the programmatic needs of Tribal communities.
- **BH2.4:** Develop flexibilities that allow tribes with multiple Federal grants to lower administrative costs, increase integration of funded programs, and enhance collaborative reporting.
- **BH2.5:** Prioritize behavioral health and related programs in all budgeting processes.
- **BH2.6:** Assess opportunities for funding traditional services including staffing and supplies.

BH3 – Tribally Directed Programs

Tribes know best the needs of their communities. However, funders may not regularly consult with tribes about their programs and may thus develop program requirements, design evaluations, and require reporting using solely a Western lens. Strategies include:

- **BH3.1:** Consult with tribes on programs that tribes are eligible for prior to developing program announcements.

- **BH3.2:** Support tribal efforts to incorporate cultural interventions into program activities that allow tribes to more effectively meet program expectations.
- **BH3.3:** Support tribally driven assessments and implementation of strengths-based, Tribal best practices.
- **BH3.4:** Increase coordination and collaboration among Federal, state, Tribal, and/or urban programs by aligning resources, decreasing competition, and improving strategic planning.
- **BH3.5:** Engage tribes about their technical assistance and other support needs prior to developing technical assistance requirements.

BH4 – Youth-Based Programming

Youth hold an important position within Tribal communities – they are the literal future for tribes. Youth-specific programs in Tribal communities require additional support given the limited resources and services that may be available locally. Learning about culture is a strong protective factor, and providing education on behavioral health issues may help reduce concerns surrounding treatment. Strategies include:

- BH4.1: Allow tribes the flexibility to engage youth in developing and implementing programming that targets American Indian and Alaska Native youth.
- BH4.2: Support targeted education for youth that incorporates learning their Native language, respective culture(s), and role that culture plays in supporting behavioral health.

BH5 – Scope of Programming

In response to service-related challenges, including, funding, staffing, facility shortages, and quality services, many tribes do not receive or are unable to provide a full continuum of services for their members. This often means that Tribal members must leave the community to receive care or not receive the services they need. Tribes have sought expansion in the scope of programming to ensure that Tribal members are able to receive vital care within their communities. Strategies include:

- **BH5.1:** Identify new models of care delivery that ensure more accessible intensive inpatient and long-term care.
- B**H5.2:** Support implementation of Tribal, Federal, and/or state collaborations that bolster wraparound services.
- **BH5.3:** Support and immediately implement a collaboration that supports early intervention services for behavioral health.
- **BH5.4:** Support expansion of telebehavioral services to additional Tribal communities or clinics.

BH6 – Law Enforcement and Justice Programs

American Indians and Alaska Natives with mental and/or substance use disorders often end up in the criminal justice system rather than receiving services. Incarceration frequently compounds already challenging preexisting conditions, and tribes are seeking greater collaboration between the behavioral health and criminal justice systems in a way that does not further victimize Native youth and adults, supports growth, and promotes healthy living. Strategies include:

- **BH6.1:** Strengthen collaborations among health, behavioral health, and justice system programs of the U.S. Department of Health and Human Services, U.S. Department of Justice, and U.S. Department of the Interior to strengthen programs for Native youth in collaboration with tribal courts to create alternatives to incarceration that incorporate tribal values, culture, and tradition in programming that addresses behavioral health issues.
- **BH6.2:** Support expansion of Tribal healing to wellness court programs of the U.S. Department of Health and Human Services, U.S. Department of Justice, and U.S. Department of the Interior to support diversion of Tribal members with a mental and/or substance use disorder from the criminal justice system to local behavioral health care.

Who can help advance behavioral health systems and support priorities?

CHART 4:

ADVANCING BEHAVIORAL HEALTH SYSTEMS AND SUPPORT

	OPPORTUNITIES					
	Individual	Family	Community	Tribal Government	State Government	Federal Government
BH1.1: Support and develop a collaboration among tribes, Tribal organizations, Tribal Colleges and Universities, and Federal agencies to establish local "grow your own" behavioral health education programs and provide basic training for local Tribal behavioral health aides (community workers).			✓	✓	✓	✓
BH1.2: Establish collaborations between tribes and Addiction Technology Transfer Centers to support education, training for certification exams, and clinical supervision opportunities for behavioral health professionals working in Tribal facilities to obtain and maintain certification.				✓		✓
BH1.3: Support the incorporation of traditional practitioners within service delivery systems and provide training on cultural and organizational competency for all employees.				✓	✓	✓
BH1.4: Actively pursue collaborations with the HRSA National Health Service Corps Program to recruit psychiatrists, behavioral health professionals, and other practitioners to work in Tribal facilities.				✓		
BH2.1: Assess state engagement with tribes and promote meaningful state/Tribal consultations.				✓	✓	✓
BH2.2: Monitor state behavioral health spending and support equitable resources and support to tribes and other entities providing services for Tribal members.				✓	✓	✓
BH2.3: Increase flexibility in funding requirements to tribes to support culturally based programming that meets the programmatic needs of Tribal communities.					✓	✓
BH2.4: Develop flexibilities that allow tribes with multiple Federal grants to lower administrative costs, increase integration of funded programs, and enhance collaborative reporting.				✓		✓
BH2.5: Prioritize behavioral health and related programs in all budgeting processes.	✓	✓	✓	✓	✓	✓
BH2.6: Assess opportunities for funding traditional services including staffing and supplies.				✓	✓	✓
BH3.1: Consult with tribes on programs that tribes are eligible for prior to developing program announcements.					✓	✓
BH3.2: Support tribal efforts to incorporate cultural interventions into program activities that allow tribes to more effectively meet program expectations.	✓	✓	✓	✓	✓	✓
BH3.3: Support tribally driven assessments and implementation of strengths-based, Tribal best practices.					✓	✓

	OPPORTUNITIES					
	Individual	Family	Community	Tribal Government	State Government	Federal Government
BH3.4: Increase coordination and collaboration among Federal, state, Tribal, and urban programs by sharing resources, decreasing competition, and improving strategic planning.				✓	✓	✓
BH3.5: Engage tribes on their technical assistance and support needs prior to articulating technical assistance requirements.					✓	✓
BH4.1: Allow tribes the flexibility to engage youth in developing and implementing programming that target American Indian and Alaska Native youth.					✓	✓
BH4.2: Support targeted education for youth that incorporates learning their Native language, respective culture(s), and role that culture plays in supporting behavioral health.	✓	✓	✓	✓	✓	✓
BH5.1: Identify new models of care delivery that ensure more accessible intensive inpatient and long-term care.				✓	✓	✓
BH5.2: Support implementation of Tribal, Federal, and/or state collaborations that bolster wraparound services.	✓	✓	✓	✓	✓	✓
BH5.3: Support and immediately implement a collaboration that supports early intervention services for behavioral health.				✓	✓	✓
BH5.4: Support expansion of telebehavioral services to additional Tribal communities or clinics.	✓	✓	✓	✓	✓	✓
BH6.1: Strengthen collaborations among health, behavioral health, and justice system programs of the U.S. Department of Health and Human Services, U.S. Department of Justice, and U.S. Department of the Interior to strengthen programs for Native youth in collaboration with tribal courts to create alternatives to incarceration that incorporate tribal values, culture, and tradition in programming that addresses behavioral health issues..				✓	✓	✓
BH6.2: Support the expansion of the Tribal healing to wellness court programs of the U.S. Department of Health and Human Services, U.S. Department of Justice, and U.S. Department of the Interior to support diversion of Tribal members with a mental and/or substance use disorder from the criminal justice system to local behavioral health care.	✓	✓	✓	✓	✓	✓

FOUNDATIONAL ELEMENT 5:

National Awareness (NA) and Visibility

Increasing the visibility of behavioral health issues is a key strategy for ensuring that stakeholders understand the unique challenges and potential solutions for American Indian and Alaska Native communities. These challenges can include geography, lack of access to basic resources, poverty, poor living conditions, and the impacts of traumatic events. Some tribes are concerned about extensive national visibility on issues that are better addressed locally, whereas other tribes believe that openly talking about and broadening engagement of appropriate authorities will lead to funding support and better solutions for their people. Increasing visibility while ensuring that Tribal governments have the ability to control messages shared can serve to strengthen a tribe's public and behavioral health response and readiness.

Federal Support for Addressing National Awareness and Visibility Priorities

The IHS funded five campaigns to increase national awareness, including "I Strengthen My Nation" (substance use prevention campaign); "Stand Up, Stand Strong" (bullying prevention campaign); "Community Is the Healer That Breaks the Silence" (suicide prevention campaign); "What Is Done to One Is Felt by All (family violence prevention campaign); and "My Mind, Body and Spirit Are Sacred" (sexual assault prevention campaign). In addition, IHS frequently shares information and highlights behavioral health resources, prevention and treatment practices.

Other examples of engagement by Federal agencies include NIH journal articles and publications on American Indian and Alaska Native substance use issues. In addition, SAMHSA developed the "Talk. They Hear You." underage drinking prevention campaign for Tribal communities and also recently published two reports on the prevention of suicide and suicide clusters in American Indian and Alaska Native Communities. The first report, "Preventing and Responding to Suicide Clusters in American Indian and Alaska Native Communities," interviews community members to learn more about the events and responses to youth suicide clusters between 2009 and 2011 and offers recommendations for Tribal communities and for Federal, state, and local collaborators. The second report, "Suicide Prevention in Alaska," informs Tribal communities, policymakers, and public health professionals about suicide prevention efforts in Native Alaska communities and recommends actions to advance future suicide prevention work within those communities.

Priority Areas and Strategies

NA1 – Tribal Capacity Building

Tribes have the ability to decide what information to share and what not to share, what warrants national attention and what does not, and what steps will benefit versus further damage their communities. Should Tribal leaders choose to address behavioral health issues locally or nationally, they will require data, support, and capacity development on ways to best communicate challenges and successes in their communities. Strategies include:

- **NA1.1:** Support and engage in capacity-building efforts to raise the collective capacity of tribes to speak about the effectiveness of culture in prevention and care and their own best practices.
- **NA1.2:** Support and raise the capacity of tribes to discuss the impact of historical and intergenerational trauma within their own communities and with external partners, if they choose.
- **NA1.3:** Actively educate Tribal communities about behavioral health in an effort to normalize topics of behavioral and emotional health.
- **NA1.4:** Support and raise the capacity of tribes to create and implement media and public relations plans.

NA2 – Tribally Directed Communication Strategies

In order to communicate effectively with media outlets, external and internal communities, and governmental collaborators, tribes need support on how best to exchange information and communicate in a timely and effective manner. These plans and strategies must be developed and managed in collaboration with tribes.

- **NA2.1:** Establish a national behavioral health communications campaign, in collaboration with tribes, to educate individuals about behavioral health issues affecting Tribal communities. The campaign would focus on specific mental and substance use disorders and/or co-occurring disorders that could be shared through multiple platforms and also tailored by tribes for local use. Broad national dissemination would ensure that urban Indian populations receive similar messages and support.

- **NA2.2:** Develop messages for American Indians and Alaska Natives that contain positive, Native-focused, media images and incorporate the voices of survivors and Tribal strengths to discuss issues and lived experiences.

- **NA2.3:** Package existing communications messages developed by Federal agencies and ensure that multiple entities leverage the messages to improve diffusion to communities requiring support and stakeholders who can assist.

- **NA2.4:** Create web-based tools and resources that Tribal leaders and officials can utilize to craft media communication and public relations strategies, especially during times of crisis or increased need.

NA3 – Collaborator Capacity Building

There are many entities that engage with tribes on health-related matters, including Federal, state, and other governments; nonprofit and community-based organizations; health and service providers; insurers; emergency response systems; and the media. These entities require continuous capacity building when working with Tribal communities to effectively engage and support change. Strategies include:

- **NA3.1:** Support establishment of targeted training and technical assistance across Federal agencies about American Indian and Alaska Native populations, sovereignty, the nature of the government-to-government relationship, and issues that contribute to well-being.

- **NA3.2:** Engage in meaningful Tribal consultation and communication.

- **NA3.3:** Support establishment of measures to increase the capacity of collaborators and stakeholders to understand the scope of the diversity and behavioral health challenges within Indian Country and how to treat this information in accordance with Tribal direction.

Who can help advance national awareness and visibility priorities?

CHART 5:

ADVANCING NATIONAL AWARENESS AND VISIBILITY PRIORITIES	OPPORTUNITIES					
	Individual	Family	Community	Tribal Government	State Government	Federal Government
NA1.1: Support and engage in capacity-building efforts to raise the collective capacity of tribes to speak about the effectiveness of culture in prevention and care and their own best practices.	✓	✓	✓	✓	✓	✓
NA1.2: Support and raise the capacity of tribes to discuss the impact of historical and intergenerational trauma within their own communities and with external partners, if they choose.	✓	✓	✓	✓	✓	✓
NA1.3: Actively educate Tribal communities about behavioral health in an effort to normalize topics of behavioral and emotional health.	✓	✓	✓	✓	✓	✓
NA1.4: Support and raise the capacity of tribes to create and implement media and public relations plans.	✓	✓	✓	✓	✓	✓
NA2.1: Establish a national behavioral health communications campaign, in collaboration with tribes, to educate individuals about behavioral health issues affecting Tribal communities. The campaign would target specific mental disorders, substance use, and/or co-occurring disorders that could be shared through multiple platforms and also tailored by tribes for local use. Broad national dissemination would ensure that urban Indian populations receive similar messages and support.				✓	✓	✓
NA2.2: Develop messages for American Indians and Alaska Natives that contain positive, Native-focused, media images and incorporate the voices of survivors and Tribal strengths to discuss issues and lived experiences.	✓	✓	✓	✓	✓	✓
NA2.3: Package existing communications messages developed by Federal agencies and ensure that multiple entities leverage the messages to improve diffusion to communities requiring support and stakeholders who can assist.	✓	✓	✓	✓	✓	
NA2.4: Create web-based tools and resources that Tribal leaders and officials can utilize to craft media communication and public relations strategies, especially during times of crisis or increased need.	✓	✓	✓	✓	✓	✓
NA3.1: Support establishment of targeted training and technical assistance across Federal agencies about American Indian and Alaska Native populations, sovereignty, the nature of the government-to-government relationship, and issues that contribute to well-being..	✓	✓	✓	✓		✓
NA3.2: Engage in meaningful Tribal consultation and communication.				✓	✓	✓
NA3.3: Institute measures to increase the capacity of collaborators and stakeholders to understand the scope of the diversity and behavioral health challenges within Indian Country and how to treat this information in accordance with Tribal direction.				✓	✓	✓

6 MOVING FORWARD

One of the messages that framed development of the TBHA remains one of the most important messages on which to frame the path forward: There is no single entity, program, or activity alone that will improve behavioral health outcomes for American Indians and Alaska Natives. Tribal leaders asked for tribes and Federal agencies to "work together differently" to improve the wellness of their communities. Through extensive conversations, Tribal leaders, Tribal administrators, and Tribal members from communities across Indian Country provided input on what they believed was best for healing their people from traumatic events compounded over time. And, despite the differences across tribes, geography, cultures, and language, they found areas of common benefit on which to frame priorities that allow for collaborative work across sectors and governments to target the factors contributing to behavioral health problems.

The National Tribal Behavioral Health Agenda is not an end but a continuing chapter in Tribal-Federal relations. It uses as a starting place the ideas and beliefs of Tribal communities to build a path forward. Within this document are examples of Federal strategic plan goals and recommendations that are being addressed and comport with the priorities and strategies of the TBHA. That is, the path for making progress on the TBHA is largely already paved. What proceeds from here are efforts to identify through existing, well-defined structures how to ensure uptake of the priorities, support meaningful collaboration, and assess progress on a continuing basis.

The framework, priorities, and strategies of the TBHA will be shared with Tribal leaders who are members of Federal Tribal advisory councils to determine areas they would like to advance that are within the scope of the agencies with whom they work. Updates from the work of these councils will be shared with the HHS Intradepartmental Council on Native American Affairs for guidance and coordination. Federal staff members who participated in the Federal Interagency Forum on developing the TBHA found the meeting a useful platform for addressing and coordinating work and requested future meetings. To that end, future meetings will be scheduled to assess progress and identify innovative ideas.

Information on collaborative actions with tribes will be documented in a "National Tribal Behavioral Health Agenda Report." The Tribal Law and Order Act's Interagency Alcohol and Substance Abuse Data Workgroup already has drafted an initial report specifically for the TBHA that includes data sets from multiple Federal departments and will serve as a data source for comparisons on the state of mental and substance use disorders in Indian Country.

Ultimately, this work requires examination and modification of some policies, programs, activities, and beliefs about developing programs that bear significance for American Indian and Alaska Native peoples. Tribal leaders have shared the power of cultural wisdom and traditional practices for their people. They have asked for all levels of government, including Tribal governments, to respect the authenticity of cultural wisdom; accept traditional ways of being, knowing, and doing; and commit to supporting their unique ideas of health and healing through multiple means. They have asked that all interested parties trust Tribal nations to do the best for their people.

Information has been shared, priorities have been identified, and a path has been established. It is now up to Tribal, Federal, and other entities to embrace and advance meaningful collaborations.

REFERENCES

ENDNOTES

1 Substance Abuse and Mental Health Services Administration (2016). Health Care and Health Systems Integration: Overview. Retrieved from http://www.samhsa.gov/health-care-health-systems-integration.

2 National Conference of State Legislatures. (2015). Federal and state recognized tribes. Washington, DC. Retrieved from http://www.ncsl.org/research/state-tribal-institute/list-of-federal-and-state-recognized-tribes.aspx.

3 U.S. Census Bureau. (2015). *FFF: American Indian and Alaska Native Heritage Month.* Retrieved December 21, 2015, from http://www.census.gov/newsroom/facts-for-features/2015/cb15-ff22.html.

4 Bureau of Indian Affairs. (2015). Frequently asked questions. Retrieved December 27, 2015, from http://www.bia.gov/FAQs/

5 Snipp, C.M. (1996). The size and distribution of the American Indian population: Fertility, mortality, migration, and residence. In G.D. Sandefur, R.R. Rindfuss, & B. Cohen (Eds.) *Changing Numbers, Changing Needs: American Indian Demography and Public Health* (pp. 17-52). Washington, DC: National Academy Press.

6 U.S. Census Bureau. (2016). *FFF: American Indian and Alaska Native Heritage Month.* Retrieved from https://www.census.gov/newsroom/facts-for-features/2016/cb16-ff22.html.

7 U.S. Census Bureau. (2010a). 2010 Census Summary File 1(SF1) 100% Data. Retrieved from http://factfinder2.census.gov.

8 U.S. Census Bureau. (2011). *Profile American: Facts for Features, American Indian and Alaska Native Heritage Month.* Washington, DC: U.S. Census Bureau.

9 U.S. Census Bureau. (2016). *FFF: American Indian and Alaska Native Heritage Month.* Retrieved from https://www.census.gov/newsroom/facts-for-features/2016/cb16-ff22.html.

10 U.S. Census Bureau. (2010b). The American Indian and Alaska Native Population: 2010. Retrieved from http://www.census.gov/prod/cen2010/briefs/c2010br-10.pdf.

11 U.S. Census Bureau. (2015). *FFF: American Indian and Alaska Native Heritage Month.* Retrieved December 21, 2015, from http://www.census.gov/newsroom/facts-for-features/2015/cb15-ff22.html.

12 Faircloth, S.C., & Tippeconnic III, J.W. (2010). The dropout/graduation crisis among American Indian and Alaska Native students: Failure to respond places the future of Native peoples at risk. *The Civil Rights Project/Proyecto Derechos Civiles at UCLA* Los Angeles, CA.

13 U.S. Department of the Interior. (2013). *2013 American Indian Population and Labor Force Report.* Washington, DC. Retrieved from http://www.bia.gov/cs/groups/public/documents/text/idc1-024782.pdf.

14 Austin, A. (2013). Native Americans and jobs: The challenge and the promise *EPI Briefing Paper* #370. Washington, DC: Economic Policy Institute.

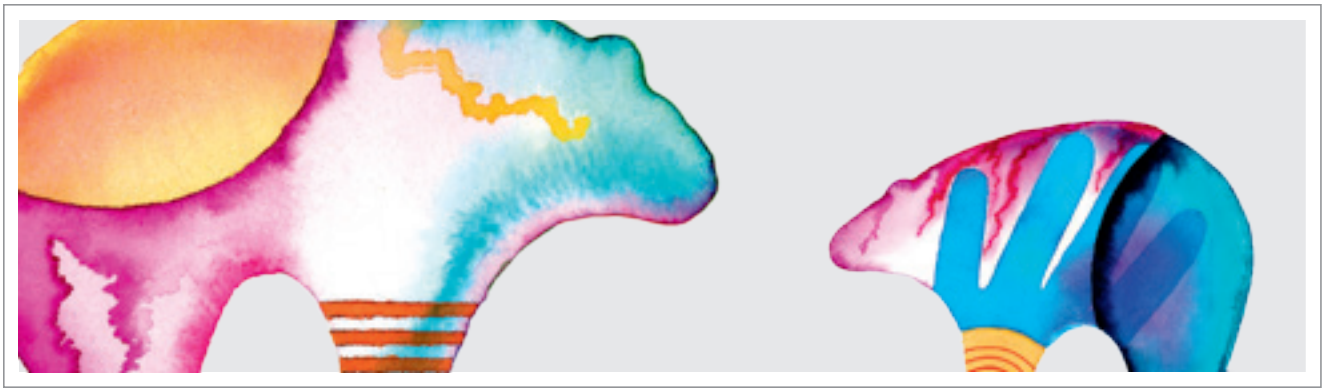
15 Indian Health Service, safe water and waste disposal facilities. Retrieved from https://www.ihs.gov/newsroom/Factsheets/safewater/

16 Hennessy, T.W., Ritter, T., Holman, R.C., Bruden, D.L., Yorita, K.L., Bulkow, L., & Smith, J. (2008). The relationship between in-home water service and the risk of respiratory tract, skin, and gastrointestinal tract infections among rural Alaska natives. *American Journal of Public Health*, 98(11), 2072-2078.

17 U.S. Census Bureau. (2016). *FFF: American Indian and Alaska Native Heritage Month.* Retrieved from https://www.census.gov/newsroom/facts-for-features/2016/cb16-ff22.html.

18 Castor, M.L., Smyser, M.S., Taualii, M.M., Park, A.N., Lawson, S.A., & Forquera, R.A. (2006). A nationwide population-based study identifying health disparities between American Indians/Alaska Natives and the general populations living in select urban counties. *American Journal of Public Health 96*(8), 1478-1484.

19 Goodkind, R.J., Ross-Toledo, K., & John, S. (2011). Rebuilding trust: A community, multiagency, state, and university partnership to improve behavioral health care for American Indian youth, their families, and communities. *Journal of Community Psychology 39*(4), 452-477.



20 Castor, M.L., Smyser, M.S., Taualii, M.M., Park, A.N., Lawson, S.A., & Forquera, R.A. (2006). A nationwide population-based study identifying health disparities between American Indians/Alaska Natives and the general populations living in select urban counties. *American Journal of Public Health 96*(8), 1478-1484.

21 Indian Health Service. (2015). Disparities. Rockville, MD. Retrieved from https://www.ihs.gov/newsroom/index.cfm/factsheets/disparities/.

22 Welty, T.K. (2002). The epidemiology of alcohol use and alcohol-related health problems among American Indians and Alaska Natives. In P.D. Mail, S. Heurtin-Roberts, S.E. Martin, & J. Howard (Eds.). *Alcohol Use Among American Indians and Alaska Natives: Multiple Perspectives on a Complex Problem* (Vol. 37, pp. 49-70). Bethesda, MD: U.S. Department of Health and Human Services.

23 Centers for Disease Control and Prevention (CDC). (2008, August 29). Alcohol-attributable deaths and years of potential life lost among American Indians and Alaska Natives – United States, 2001-2005. *MMWR. Morbidity and Mortality Weekely Reports.* Retrieved from https://www.cds.gov/mmwr/preview/mmwrhtml/mm5734a3.htm.

24 Indian Health Revise. *Regional Difference in Indian Health: Vol 2 edition.* Rockville, MD: U.S. Department of Health and Human Services.

25 Alcantara, C., & Gone, J.P. (2007). Reviewing suicide in Native American communities: Situating risk and protective factors within a transactional-ecological framework. *Death Studies 31*(5), 457-477. doi: 10.1080/07481180701244587.

26 Stannard, D.E. (1992). *American Holocaust: The Conquest of the New World.* New York, NY: Oxford University Press.

27 Thornton, R. (1987). *American Indian holocaust and survival: A population history since 1492.* Norman, OK: University of Oklahoma Press.

28 Brave Heart, M.Y.H. (1999a). Gender differences in the historical trauma response among the Lakota. *Journal of Health and Social Policy 10*(4), 1-21.

29 Brave Heart, M.Y.H. (1999b). Oyate Ptayela: Rebuilding the Lakota Nation through addressing historical trauma among Lakota parents. *Journal of Human Behavior in the Social Environment 2*(1-2), 109-126.

30 Brave Heart, M.Y.H. (2000). Wakiksuyapi: Carrying the historical trauma of the Lakota. *Tulane Studies in Social Welfare* (21-22), 245-266.

31 Braveheart, M.Y.H., & DeBruyn, I.M. (1998). The American Indian Holocaust: Healing historical unresolved grief. *American Indian and Alaska Native Mental Health Research 8*(2), 56-78.

32 Barnes, P.M., Adams, P.F., & Powell-Griner, E. (2010). Health characteristics of the American Indian or Alaska Native adult population: United States, 2004-2008. *National Health Statistics Report 9*(20), 1-22.

33 Bombay, A., Matheson, K., & Anisman, H. (2011). The impact of stressors on second generation Indian residential school survivors. *Transcultural Psychiatry 48*(4), 367-391.

34 Lemstra, M., Rogers, M., Thompson, A., Moraros, J., & Buckingham, R. (2012). Risk indicators associated with injection drug use in the Aboriginal population. *AIDS Care 24*(11), 1416-1424.

35 Elias, B., Mignone, J., Hall, M., Hong, S.P., Hart, L., & Sareen, J. (2012). Trauma and suicide behavior histories among a Canadian indigenous population: An empirical exploration of the potential role of Canada's residential school system. *Social Science & Medicine 74*(10), 1560-1569.

36 Substance Abuse and Mental Health Services Administration. SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. HHS publication No (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

37 Brockie, T.N., Heinzelmann, M., & Gill, J. (2013). A framework to examine the role of epigenetics in health disparities among Native Americans. *Nursing Research and Practice 2013*(Article ID 310395). doi: 1155/2013/410395.

38 Whitbeck, L.B., Adams, G.W., Hoyt, D.R., & Chen, X. (2004a). Conceptualizing and measuring historical trauma among American Indian people. *American Journal of Community Psychology 33*(3-4), 119-130.

39 Whitbeck, L.B., Chen, X., Hoyt, D.R., & Adams, G.W. (2004b). Discrimination, historical loss, and enculturation: Culturally specific risk and resiliency factors for alcohol abuse among American Indians. *Journal of Studies on Alcohol and Drugs 65*(4), 409-418.

40 Hodge, F.S. (2012). No meaningful apology for American Indian unethical abuses. *Ethics & Behavior 22*(6), 431-444. doi: 101080/10508422.2012.730788.

41 Spruhan, P. (2006). A legal history of blood quantum in federal Indian law to 1935. *South Dakota Law Review 51*, 1-50.

42 Frosch, D. (2015). Federal panel reviewing Native American sentencing. Wall Street Journal. Retrieved from http://www.wsj.com/articles/federal-panel-reviewing-native-american-sentencing-1429608601.

43 Greenfield, L.A., & Smith, S.K. (1999). American Indians and crime. Washington, DC: U.S. Department of Justice. Retrieved from http://www.bjs.gov/content/pub/pdf/aic.pdf.

44 Walker, C. (2014). Judge: SD Indian child welare case can proceed. *Yahoo! News.* http://news.yahoo.com/judge-sd-indian-child-welfare-case-proceed-214004318.html.

45 Borowsky, I.W., Resnick, M.D., Ireland, M., & Blum, R.W. (1999). Suicide attempts among American Indian and Alaska Native youth: Risk and protective factors. *Archives of Pediatric Adolescent Medicine 153*, 573-580.

46 Clark, D.B., Lesnick, L., & Hegedus, A.M. (1997). Traumas and other adverse life events in adolescents with alcohol abuse and dependency. *Journal of the American Academy of Child and Adolescent Psychiatry 36*(12), 1744-1751.

47 Bohn, D.K. (2003). Lifetime physical and sexual abuse, substance abuse, depression, and suicide attempts among Native American women. *Issues in Mental Health Nursing 24*(3) (333-352).

48 Goodkind, R.J., Hess, J.M., Gorman, B., & Parker, D.P. (2012). "We're Still in a Struggle": Dine' resilience, survival, historical trauma, and healing. *Qual Health Res, 22*(8), 1019-1036. doi: 10.1177/1049732312450324.

49 Goodkind, R.J., Hess, J.M., Gorman, B., & Parker, D.P. (2012). "We're Still in a Struggle": Dine' resilience, survival, historical trauma, and healing. *Qual Health Res, 22*(8), 1019-1036. doi: 10.1177/1049732312450324.

50 Fixico, D.L. (2013). *Indian resilience and rebuilding: Indigenous nations in the modern American West*: University of Arizona Press.

51 Annie E. Casey Foundation. (2009). Seeing the protective rainbow: How families survive and thrive in the American Indian and Alaska Native community. Retrieved from http://www.aecf.org/m/resourcedoc/aecf-howfamiliessurviveindianandalaskan-2009.pdf#page=1.

52 National Aboriginal Community Controlled Health Organization. (2009). Retrieved from http://www.naccho.org.au/aboriginal-health/definitions/.

53 National Aboriginal Community Controlled Health Organization. (2009). Retrieved from http://www.naccho.org.au/aboriginal-health/definitions/.

54 Bombay, A., Matheson, K., & Anisman, H. (2011). The impact of stressors on second generation Indian residential school survivors. *Transcultural Psychiatry 48*(4), 367-391.

55 Lemstra, M., Rogers, M., Thompson, A., Moraros, J., & Buckingham, R. (2012). Risk indicators associated with injection drug use in the Aboriginal population. *AIDS Care 24*(11), 1416-1424.

56 Elias, B., Mignone, J., Hall, M., Hong, S.P., Hart, L., & Sareen, J. (2012). Trauma and suicide behavior histories among a Canadian indigenous population: An empirical exploration of the potential role of Canada's residential school system. *Social Science & Medicine 74*(10), 1560-1569.

57 Hess, K.L., Javanbakht, M., Brown, J.M., Weiss, R.E., Hsu, P., & Gorback, P.M. (2012). Intimate partner violence and sexually transmitted infections among young adult women. *Sexually Transmitted Diseases 39*(5), 366-371. doi: 10.1097/OLQ.0b013e3182478fa5.

58 Laudenslager, M.L., Noonan, C., Jacobsen, C., Goldberg, J., Buchwald, D., Bremner, J.D., & Manson, S.M. (2009). Salivary cortisol among American Indians with and without posttraumatic stress disorder (PTSD): Gender and alcohol influences. *Brain, Behavior, and Immunity 23*(5), 658-662. doi: 10.1016/j.bbi.2008.12.007.

59 Perry, S.W. (2004). American Indians and crime: A BJS statistical profile, 1992-2002. Washington, DC: U.S. Department of Justice, Office of Justice Programs, National Institute of Justice.

60 Greenfield, L.A., & Smith, S.K. (1999). American Indians and crime. Washington, DC: U.S. Department of Justice. Retrieved from http://www.bjs.gov/content/pub/pdf/aic.pdf.

61 Ackard, D.M., Eisenberg, M.E., Neumark-Sztainer, D. (2007). Long-term impact of adolescent dating violence on the behavioral and psychological health of male and female youth. *Journal of Pediatrics 151*(5), 476-481.

62 Alleyne-Green, B., Coleman-Cowger, V.H., Henry, D.B. (2012). Dating violence perpetration and/or victimization and associated sexual risk behaviors among a sample of innter-city African American and Hispanic females. *Journal of Interpersonal Violence 27*(8), 1457-1473. doi: 10.1177/0886260511425788.

63 Coker, A.L., McKeown, R.E., Sanderson, M., Davis, K.E., Valois, R.F., Huebner, E.S. (2000). Severe dating violence and quality of life among South Carolina high school students. *American Journal of Preventive Medicine 19*(4), 220-227.

64 Lormand, D.K., Markham C.M., Peskin, M.F., Byrd, T., Addy, R.C., Baumler, E.R., Tortolero, S.R. (2013). Dating violence among urban, minority, middle school youth and associated sexual risk behaviors and substance use. *Journal of School Health 83*(6), 415-421.

65 Roberts, T.A., Klein, J.D., & Fisher, S. (2003). Longitudinal effect of intimate partner abuse on high-risk behavior among adolescents. *Archives of Pediatrics and Adolescent Medicine 157*, 875-881.

66 Silverman, J.G., Raj, A., Mucci, L.A., & Hathaway, J.E. (2001). Dating violence against adolescent girls and associated substance use, unhealthy weight control, sexual risk behavior, pregnancy, and suicidality. *Journal of the American Medical Association 286*(5), 572-579.

67 Temple, J. R., & Freeman, D. (2011). Dating violence and substance use among ethnically diverse adolescents. *Journal of Interpersonal Violence, 26*(701-718).

68 Wolitzky-Taylor, K.B., Ruggiero, K.J., Danielson, C.K., Resnick, H.S., Hanson, R.F., Smith, D.W, Saunders, B.E. & Kilpatrick, D.G. (2008). Prevalence and correlates of dating violence in a national sample of adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry 47*(7), 755-762.

69 Morsette, A., van den Pol, R., Schuldberg, D., Swaney, G., & Stolle, D. (2012). Cognitive behavioral treatment for trauma symptoms in American Indian youth: Preliminary findings and issues in evidence-based practice and reservation culture. *Advances in School Mental Health Promotion 5*, 51-62. doi: 10.1080/1754730X.2012.664865.

70 Greenfield, L.A., & Smith, S.K. (1999). American Indians and crime. Washington, DC: U.S. Department of Justice. Retrieved from http://www.bjs.gov/content/pub/pdf/aic.pdf.

71 Lakota People's Law Project. (2015). Native lives matter. *Lakota People's Law Project.*

72 Males, M. (2014). Who are police killing. *Center on Juvenile and Criminal Justice.* Retrieved from www.cjcj.org website: http://www.cjcj.org/news/8113.

73 Perry, S.W. (2004). American Indians and crime: A BJS statistical profile, 1992-2002. Washington, DC: U.S. Department of Justice, Office of Justice Programs, National Institute of Justice.

74 Ryan, L. (2015). Divest from incarcerating youth, reinvest in our youth. National Council on Crime & Delinquency. Retrieved from http://www.nccdglobal.org/blog/divest-from-incarcerating-youth-reinvest-in-our-youth.

75 Scott, D. (2015). *Rapid risk assessments for American Indian youth.* Believing in Native Generations. Anadarko, OK. Retrieved from http://bling562.org/projects/

76 La Vigne, N.G., Davis, E., & Brazzell, D. (2008). Broken bonds: Understanding and addressing the needs of children with incarcerated parents. Washington, DC: Urban Institute.

77 General Assembly of the Commmonwealth of Pennsylvania. (2011). *The effects of parental incarceration on children: Needs and responsive services.* Retrieved from http://jsg.legis.state.pa.us/resources/documents/ftp/documents/children%20of%20incarcerated%20parents.pdf.

78 U.S. Government Accountability Office. (2011). Child welfare: More Information and Collaboration Could Promote Ties Between Foster Care Children and Their Incarcerated Parents. Retrieved from http://www.gao.gov/products/GAO-11-863#sthash.yUnhMngw.dpuf.

79 La Vigne, N.G., Davis, E., & Brazzell, D. (2008). Broken bonds: Understanding and addressing the needs of children with incarcerated parents. Washington, DC: Urban Institute.

80 Phillips, S.D., & Gleeson, J.P. (2007). What we know now that we didn't know then about the criminal justice system's involvement in families with whom child welfare agencies have contact. Retrieved from http://www.f2f.ca.gov/res/pdf/WhatWeKnowNow.pdf#sthash.yUnhMngw.dpuf.

81 U.S. Department of Veterans Affairs (2015). American Indian and Alaska Native Veterans: 2013 American Community Survey. Retrieved from http://www.va.gov/vetdata/docs/specialreports/aianpaper9-12-06final.pdf

82 U.S. Department of Housing and Urban Development. (2015). *Native Americans in the military.* Retrieved from http://portal.hud.gov/hudportal/HUD?src=/program_offices/public_indian_housing/ih/codetalk/onap/veterans.

83 Holiday, L.F., Bell, G., Klein, R.E., & Wells, M.R. (2006). *American Indian and Alaska Native veterans: Lasting contributions.* Washington, DC: VA Office of Policy Assistant Secretary for Policy, Planning, and Preparedness.

84 Friedman, M.J., Ashcraft, M.L., Beals, J.A., Keane, T.M., Manson, S.M., & Marsella, A.J. (1997). *Maatsunaga Vietnam Veterans Project (Volumes 1 and 2)*: National Center for Posttraumatic Stress Disorder and National Center for American Indian and Alaska Native Mental Health Research.

85 Kulka, R.A., Schlenger, W.A., Fairbanks, J.A., Hough, R.L., Jordan, B.K., Marmar, C.R., & Cranston, A.S. (1990). *Trauma anad the Vietnam war generation: Report of findings from the National Vietnam Veterans Readjustment Study.* New York: Brunneer/Mazel.

86 Jacobsen, L.K., Southwick, S.M., & Kosten, T.R. (2001). Substance use disorders in patients with posttraumatic stress disorder: A review of the literature. *American Journal of Pschiatry 158*(8), 1184-1190. doi: 10.1176/appi.ajp.1184.

87 Ouimette, P., Read, J.P., Wade, M., & Tirone, V. (2010). Modeling associations between posttraumatic stress symptoms and substance use. *Addictive Behaviors 35*(1), 64-67. doi: 10.1016/j.addbeh.2009.08.009.

88 U.S. Department of Veterans Affairs (2015). American Indian and Alaska Native Veterans: 2013 American Community Survey. Retrieved from http://www.va.gov/vetdata/docs/SpecialReports/AIANReport2015.pdf

89 Urban Indian Health Institute. (2012). *Addressing Depression Among American Indians and Alaska Natives: A Literature Review*. Seattle, WA: Urban Indian Health Institute.

90 Urban Indian Health Commission. (2007). *Invisible Tribes: Urban Indians and Their Health in a Changing World*. Seattle, WA.

91 Substance Abuse and Mental Health Services Administration. (2007). *Results from the 2006 National Survey on Drug Use and Health: National findings.* Rockville, MD.

92 Forrest, K.Y.Z., Leeds, M., Williams, A., & Lin, Y. (2001). *High depression rate in Native American children.* Paper presented at the 129th Annual Meeting of APHA. https://apha.confex.com/apha/129am/techprogram/paper_20430.htm.

93 U.S. Department of Health and Human Services (2010). National healthcare disparities report. Retrieved from http://www.ahrq.gov/research/findings/nhqrdr/nhqrdr10/index.html

94 Wolsko, C., Lardon, C., Mohatt, G.V., & Orr, E. (2007). Stress, coping, and well-being among the Yup'ik of the Yukon-Kuskokwim delta: The role of enculturation. *International Journal of Circumpolar Health 66*, 51-61.

95 Kunitz, S.J. (2008a). Changing patterns of mortality among American Indians. *American Journal of Public Health 98*(3), 404-411.

96 Scott, D. (2015). *Rapid risk assessments for American Indian youth.* Believing in Native Generations. Anadarko, OK. Retrieved from http://bling562.org/projects/

97 Hall, K. (2015). How grief affects the body. Retrieved from http://www.qualityhealth.com/depression-articles/how-grief-affects-body.

98 Atkins, S., Lanfear, C., Cline, S., & Mosher, C. (2013). Patterns and correlates of adult American Indian substance use. *Journal of Drug Issues 43*(4), 497-516. Retrieved on May 12, 2015, from http://search.proquest.com.library.capella.edu/docview/1450252713?accountid=27965.

99 Trimble, J.E. (2007). Prolegomena for the connotation of construct use in the measurement of ethnic and racial identity. *Journal of Counseling Psychology 54*(3), 247-258.

100 Substance Abuse and Mental Health Services Administration. (2010). *Results From the 2009 National Survey on Drug Use and Health: Volume I. Summary of National Findings.* HHS Publication No. SMA 10-4586). Rockville, MD: Office of Applied Studies. Retrieved from http://oas.samhsa.gov/NSDUH/2k9NSDUH/2k9Results.htm.

101 Beals, J., Spicer, P., Mitchell, C.M., Novins, D.K., & Manson, S.M. (2003). Racial disparities in alcohol use: Comparison of two American Indian reservation populations with national data. *American Journal of Public Health 93*(10), 1683-1685.

102 Walls, M.L., Whitbeck, L.B., Hoyt, D.R., & Johnson, K.D. (2007). Early-onset alcohol use among Native American youth: Examining female caretaker influence. *Journal of Marriage and Family 69*(2), 451-464.

103 Mitchell, C.M., Beals, J., Novins, D.K., & Spicer, P. (2003). Drug use among two American Indian populations: Prevalence of lifetime use and DSM-IV substance use disorders. *Drug and Alcohol Dependence 69*, 29-41.

104 Nez-Henderson, P., Jacobsen, C., & Beals, J. (2005). Correlates of cigarette smoking among selected Southwest and Northern Plains tribal groups: The AI-SUPERPFP study. *American Journal of Public Health 95*(5), 867-872.

105 Beals, J., Spicer, P., Mitchell, C.M., Novins, D.K., & Manson, S.M. (2003). Racial disparities in alcohol use: Comparison of two American Indian reservation populations with national data. *American Journal of Public Health 93*(10), 1683-1685.

106 O'Connell, J.M., Novins, D.K., Beals, J., & Spicer, P. (2005). Disparities in patterns of alcohol use among reservation-based and geographically dispersed American Indian populations. *Alcoholism: Clinical and Experimental Research* 29(1), 107-116.

107 S*ubstance Use in American Indian Youth is Worse than We Thought* (2014). Retrieved from https://www.drugabuse.gov/about-nida/noras-blog/2014/09/substance-use-in-american-indian-youth-worse-than-we-thought

108 Kunitz, S.J. (2008b). Risk factors for polydrug use in a Native American population. *Substance Use and Misuse* 43, 331-339.

109 Novins, D.K. (2004). Substance use: The hazards for progression for adolescents ages 14 to 20. *Journal the American Academy of Child and Adolescent Psychiatry* 43, 316-324.

110 Whitbeck, L.B., Yu, M., Johnson, K.K., Hoyt, D.R., & Walls, M.L. (2008). Diagnostic prevalence rates from early to mid-adolescence among indigenous adolescents: First results from a longitudinal study. *Journal of the American Academy of Child and Adolescent Psychiatry 47*(8), 890-900.

111 O'Connell, J.M., Novins, D.K., Beals, J., & Spicer, P. (2005). Disparities in patterns of alcohol use among reservation-based and geographically dispersed American Indian populations. *Alcoholism: Clinical and Experimental Research 29*(1), 107-116.

112 Northwest Portland Area Indian Health Board IDEA-NW Project. 2016. Unpublished death certificate data from Idaho, Oregon, and Washington.

113 Great Lakes Inter-Tribal Council (GLITC), Substance Abuse and Mental Health Services Administration Strategic Prevention Framework State Incentive Grant (SPF-SIG) #5U79SP013935. WINAPC SPF-SIG: 2011 Aggregated Community Assessment. Prepared by BEAR Consulting, LLC (2012).

114 Suicide Prevention Resource Center. (2011). *Suicide Among Racial/Ethnic Populations in the U.S. American Indians/Alaska Natives.* Newton, MA.

115 Jiang, C., Mitran, A., Miniño, A., Ni, H. (2015). Racial and Gender Disparities in Suicide Among Young Adults Aged 18-24: United States, 2009-2013. Retrieved from http://www.cdc.gov.nchs/data/hestat/suicide/racial_and_gender_2009_2013.pdf

116 Alaska Native Epidemiology Center & Alaska Native Tribal Health Consortium. (2009). Alaska Native health Status Report. Anchorage, AK.

117 Taylor, M.A., Anderson, E.M., & Bruguier Zimmerman, M.J.B. (2014). Suicide prevention in rural, tribal communities: The intersection of challenge and possibility. *Journal of Rural Mental Health 38*(2), 87-97.

118 Strickland, J. (1997). Suicide among American Indian, Alaska Native, and Canadian aboriginal youth: Advancing the research agenda. *International Journal of Mental Health, 25*(4), 11-32.

119 U.S. Department of Health and Human Services. (2009a). *An American Indian/Alaska Native Suicide Prevention Hotline: Literature and Discussion With Experts, November 2009.* Retrieved from https://aspe.hhs.gov/basic-report/aian-suicide-prevention-hotline-literature-review-and-discussion-experts#risk.

120 Strickland, J. (1997). Suicide among American Indian, Alaska Native, and Canadian aboriginal youth: Advancing the research agenda. *International Journal of Mental Health, 25*(4), 11-32.

121 Anda, R.F., Butchart, A., Felitti, V.J., & Brown, D.W. (2010). Building a framework for global surveillance of the public health implications of adverse childhood experiences. *American Journal of Preventive Medicine 39*, 93-98. doi: 10.1016/j.amepre.2010.03.015

122 Strickland, J. (1997). Suicide among American Indian, Alaska Native, and Canadian aboriginal youth: Advancing the research agenda. *International Journal of Mental Health, 25*(4), 11-32.

123 Walls, M.L., Whitbeck, L.B., Hoyt, D.R., & Johnson, K.D. (2007). Early-onset alcohol use among Native American youth: Examining female caretaker influence. *Journal of Marriage and Family 69*(2), 451-464.

124 Goodkind, R.J., Hess, J.M., Gorman, B., & Parker, D.P. (2012). "We're Still in a Struggle": Dine' resilience, survival, historical trauma, and healing. *Qual Health Res, 22*(8), 1019-1036. doi: 10.1177/1049732312450324.

125 Cashin, J. (2001). Trauma and multigenerational trauma caused by genocide and oppression: A comparison of Western and Native American healing methods. *ProQuest Information and Learning* (61), 6758.

126 Frank, J.D. (1973). *Persuasion and healing.* Baltimore: Johns Hopkins University Place.

127 Goodkind, R.J., Hess, J.M., Gorman, B., & Parker, D.P. (2012). "We're Still in a Struggle": Dine' resilience, survival, historical trauma, and healing. *Qual Health Res, 22*(8), 1019-1036. doi: 10.1177/1049732312450324.

128 Whitesell, N.R., Beals, J., BigCrow, C., Mitchell, C.M., & Novis, D.K. (2012). Epidemiology and etiology of substance use among American Indian and Alaska Natives: Risk, protection, and implications for prevention. *American Journal of Drug and Alcohol Abuse 38*(5), 376-382. doi: 10.3109/000952990.2012.694527.

129 Manson, S.M. (2001). *Behavioral health services for American Indians: Need, use, and barriers to effective care*. Washington, DC: American Public Health Association.

130 Barlow, L.T., & Thompson, K.R. (2009). *Re-kindling the fire: Healing historical trauma in Native American prison inmates*: In Psychiatrists and Traditional Healers – Unwitting Partners in Global Mental Health. M. In Incayawar, R. Wintrob and L. Bouchard, Eds. Oxford, Wiley Blackwell.

131 Wright, S., Nebelkoph, E., King, J., Maas, M., Patel, C., & Samuel, S. (2011). Holistic system of care: Evidence of effectiveness. *Substance Use and Misuse 46*(11), 1420-1430.

132 Whitesell, N.R., Beals, J., BigCrow, C., Mitchell, C.M., & Novis, D.K. (2012). Epidemiology and etiology of substance use among American Indian and Alaska Natives: Risk, protection, and implications for prevention. *American Journal of Drug and Alcohol Abuse 38*(5), 376-382. doi: 10.3109/000952990.2012.694527.

133 Brown, B.G., Baldwin, J.A., & Walsh, M.L (2012). Putting tribal nations first: Historical trends, current needs, and future directions in substance use prevention for American Indian and Alaska youths. In C. Camp-Yeaky (Series Ed.) & S.R. Notaro (Vol. Ed.), *Advances in Education in Diverse Communities: Research, Policy and Praxis. 9*, pp. 3-47).

134 Brave Heart, M.Y.H. (1998). The return to the sacred path: Healing the historical trauma and historical unresolved grief response among the Lakota through a psychoeducational group intervention. *Smith College Studies in Social Work 68*(3), 288-305.

135 Evans-Campbell, T. (2008). Historical trauma in American Indian/Native Alaska communities: A multilevel framework for exploring impacts on individuals, families, and communities. *Journal of Interpersonal Violence 23*(3), 316-338.

136 Fisher, P.A., & Ball, T.J. (2003). Tribal participatory research: Mechanisms of a collaborative model. *American Journal of Community Psychology 32*(3-4), 207-216.

137 Gone, J.P. (2009). A community-based treatment for Native American historical trauma: Prospects for evidence-based practice. *Journal of Consulting and Clinical Psychology 77*(4), 751-762.

138 Goodkind, R.J., Ross-Toledo, K., & John, S. (2011). Rebuilding trust: A community, multiagency, state, and university partnership to improve behavioral health care for American Indian youth, their families, and communities. *Journal of Community Psychology 39*(4), 452-477.

139 McCabe, G.H. (2007). The healing path: a culture and community-derived indigenous therapy model. *Psychotherapy 44*(2), 148-160.

140 Strickland, C.J., Walsh, E., & Cooper, M. (2006). Healing fractured families: Parents' and elders' perspectives on the impact of colonization and youth suicide prevention in a Pacific Northwest American Indian tribe. *Journal of Transcultural Nursing 17*(1), 5-12.

141 Walters, K.L., Simoni, J.M., & Evans-Campbell, T. (2002). Substance use among American Indians and Alaska Natives: Incorporating culture in an "Indigenist" stress-coping paradigm. *Public Health Reports 117*(1), 104-117.

142 American Psychological Association. (2006). Evidence-based practice in psychology. *American Psychologist 61*, 271-285. doi: 10.1037/0003-066X.61.4.271.

143 Indian Health Manual, Special General Memorandum 94-8: Statement of Policy for the Traditional Cultural Advocacy Program. July 29, 1994. Retrieved from: https://www.ihs.gov/ihm/index.cfm?module=dsp_ihm_sgm_main&s-gm=ihm_sgm_9408.

144 Coyhis, D., & Simonelli, R. (2008). The Native American Healing Experience. *Substance Use and Misuse 43*(12-13), 1927-1949.

145 Taylor, M.A., Anderson, E.M., & Bruguier Zimmerman, M.J.B. (2014). Suicide prevention in rural, tribal communities: The intersection of challenge and possibility. *Journal of Rural Mental Health 38*(2), 87-97.

146 Goodkind, R.J., Hess, J.M., Gorman, B., & Parker, D.P. (2012). "We're Still in a Struggle": Dine' resilience, survival, historical trauma, and healing. *Qual Health Res, 22*(8), 1019-1036. doi: 10.1177/1049732312450324.

147 Urban Indian Health Institute. (2012). *Addressing Depression Among American Indians and Alaska Natives: A Literature Review*. Seattle, WA: Urban Indian Health Institute.

148 Goodkind, R.J., Hess, J.M., Gorman, B., & Parker, D.P. (2012). "We're Still in a Struggle": Dine' resilience, survival, historical trauma, and healing. *Qual Health Res, 22*(8), 1019-1036. doi: 10.1177/1049732312450324.

149 Urban Indian Health Institute. (2012). *Addressing Depression Among American Indians and Alaska Natives: A Literature Review*. Seattle, WA: Urban Indian Health Institute.

150 Roubideaux, Y. (2004). A review of the quality of health care for American Indians and Alaska Natives. The Commonwealth Fund

151 Indian Health Service. (2011). *Inpatient mental health assessment*. Retrieved from http://www.ihs.gov/newsroom/includes/themes/newihstheme/display_objects/documents/FINAL_IHCIA_InpatientMH_Assessment_Final.pdf.

152 Indian Health Service 2016 Profile. Retrieved from https://www.ihs.gov/newsroom/index.cfm/factsheets/ihsprofile/.

153 Roberts, J., & Jones, J.D. (2004). Health disparities challenge public health among Native Americans. *Northwest Public Health* (Fall/Winter), 8-10.

154 Urban Indian Health Commission. (2007). *Invisible Tribes: Urban Indians and Their Health in a Changing World*. Seattle, WA.

155 Indian Health Service. 2011. Inpatient mental health assessmemt. Retrieved from https://www.ihs.gov/newsroom/includes/themes/newihstheme/display_objects/documents/FINAL_IHCIA_InpatientMH_Assessment_Final.pdf

156 Indian Health Service. (2011). *Inpatient mental health assessment*. Retrieved from http://www.ihs.gov/newsroom/includes/themes/newihstheme/display_objects/documents/FINAL_IHCIA_InpatientMH_Assessment_Final.pdf.

157 Roberts, J., & Jones, J.D. (2004). Health disparities challenge public health among Native Americans. *Northwest Public Health* (Fall/Winter), 8-10.

158 Roubideaux, Y. (2005). Beyond Red Lake – The persistent crisis in American Indian health care. *The New England Journal of Medicine 353*(18), 1881-1883.

159 Woodard, S. (2012). Suicide is epidemic for American Indian youth: What more can be done? *NBCNews*. Retrieved from http://investigations.nbcnews.com/_news/2012/10/10/14340090-suicide-is-epidemic-for-american-indian-youth-what-more-can-be-done.

160 U.S. Department of Health and Human Services. How does the Affordable Care Act impact American Indians and Alaska Natives? Retrieved January 17, 2016, from http://www.hhs.gov/healthcare/facts-and-features/fact-sheets/aca-and-american-indian-and-alaska-native-people/index.html.

161 Vestal, C. (2013). Affordable Care Act a hard sell for Native Americans. *Stateline*. Retrieved from http://www.usatoday.com/story/news/nation/2013/10/15/stateline-obamacare-native-americans/2986747/.

162 Indian Health Service. (2011). *Inpatient mental health assessment*. Retrieved from http://www.ihs.gov/newsroom/includes/themes/newihstheme/display_objects/documents/FINAL_IHCIA_InpatientMH_Assessment_Final.pdf.

163 Office of Inspector General. (2011). *Access to mental health services at Indian Health Service and tribal facilities*. Washington, DC. Retrieved from http://oig.hhs.gov/oei/reports/oei-09-08-00580.pdf.

164 U.S. Department of Health and Human Services. (2011). *Behavioral Health Fact Sheet*. Rockville, MD. Retrieved from http://www.ihs.gov/PublicAffairs/IHSBrochure/Bhealth.asp.

165 Urban Indian Health Institute. (2011). *Community Health Profile: National Aggregate of Urban Indian Health Organization Service Areas*. Seattle, WA. Retrieved from http://www.uihi.org/wp-content/uploads/2011/12/COmbined-UIHO-CHP_Final.pdf.

166 Manson, S.M. (2001). *Behavioral health services for American Indians: Need, use, and barriers to effective care*. Washington, DC: American Public Health Association.

167 Novins, D.K., Moore, L.A., Beals, J., & Kaufman, C.E. (2012). A framework for conducting a national study of substance abuse treatment programs serving American Indian and Alaska Native communities. *American Journal of Drug and Alcohol Abuse 38*(5). doi: 10.3109/00952990.2012.694529.

168 U.S. Department of Health and Human Services. (2014). *Access to Mental Health Services at Indian Health Service and Tribal Facilities*.

169 Office of Inspector General. (2016). Indian Health Service Hospitals: Longstanding Challenges Warrant Focused Attention to Support Quality Care (oei-06-14-00011). Washington, DC. Retrieved from https://oig.hhs.gov/oei/reports/oei-06-14-00011.pdf.

170 Urban Indian Health Institute. (2012). *Addressing Depression Among American Indians and Alaska Natives: A Literature Review*. Seattle, WA: Urban Indian Health Institute.

171 Indian Health Service. (2011). *Inpatient mental health assessment*. Retrieved from http://www.ihs.gov/newsroom/includes/themes/newihstheme/display_objects/documents/FINAL_IHCIA_InpatientMH_Assessment_Final.pdf.

172 Indian Health Service Quality Framework 2016 – 2017. Retrieved from https://www.ihs.gov/newsroom/includes/themes/newihstheme/display_objects/documents/IHS_2016-2017_QualityFramework.PDF

173 Connor, K.O., Koeske, G., & Brown, C. (2009). Racial differences in attitudes toward professional mental health treatment: The mediating effect of stigma. *Journal of Gerontological Social Work 52*, 695-712. doi: 10.1080/01634370902914372.

174 Gonzalez, J.M., Alegria, M., & Prihoda, T.J. (2005). How do attitudes toward mental health treatment vary by age, gender, and ethnicity/race in young adults? *Journal of Community Psychology 33*, 611-629. doi: 10.1002/jcop.20071.

175 Poleshuck, E.L., Cerrito, B., Leshoure, N., Finocan-Kaag, G., & Kearney, M.H. (2013). Underserved women in a women's health clinic describe their experiences of depressive symptoms and why the have low uptake of psychotherapy. *Community Mental Health Journal 49*, 50-60. doi: 101007/s10597-012-9500-7.

176 McCabe, K.M. (2002). Factors that predict premature termination among Mexican-American children in outpatient psychotherapy. *Journal of Child and Family Studies 11*, 347-359. doi: 10.1023/A:1016876224388.

177 O'Sullivan, M.J., Peterson, P.D., Cox, G.B., & Kirkeby, J. (1989). Ethnic populations: Community mental health services ten years later. *American Journal of Community Psychology 17*, 17-30. doi: 10.1007/BF00931200.

178 Coyhis, D., & Simonelli, R. (2008). The Native American Healing Experience. *Substance Use and Misuse 43*(12-13), 1927-1949.

179 Gone, J.P., & Trimble, J.E. (2012). American Indian and Alaska Native mental health: Diverse perspectives on enduring disparities. *Annual Review of Clinical Psychology 8*, 131-160. doi: 10.1146/annrev-climpsy-032511-143127.

180 Jimenez, D.E., Bartels, S.J., Cadenas, V., & Alegria, M. (2013). Stigmatizing attitudes toward mental illness among racial/ethnic older adults in primary care. *International Journal of Geriatric Psychiatry 28*, 1061-1068. doi: 10.1002/gps.3928. Jimenez, D.E., Bartels, S.J., Cadenas, V., & Alegria, M. (2013). Stigmatizing attitudes toward mental illness among racial/ethnic older adults in primary care. *International Journal of Geriatric Psychiatry 28*, 1061-1068. doi: 10.1002/gps.3928.

181 Vogel, D.L., Wade, N.G., & Hackler, A.H. (2007). Perceived social stigma and the willingness to seek counseling: The mediating roles of self-stigma and attitudes toward counseling. *Journal of Counseling Psychology 54*, 40-50. doi: 10.1037/0022-0167.54.1.40.

182 Zhang, N., & Dixon, D.N. (2003). Acculturation and attitudes of Asian international students toward seeking psychological help. *Journal of Multicultural Counseling and Development 31*, 205-222. doi: 10.1002/j.2161-191.2003.tb00544.x.

183 Drabiak-Syed, K. (2010). Lessons from Havasupai Tribe v. Arizona State University Board of Regents: Recognizing Group, Cultural, and Dignitary Harms as Legitimate Risks Warranting Integration into Research Practice. *Journal of Health & Biomedical Law, VI*: 175-225.

184 Advisory Committee on Human Radiation Experiments. *Chapter 12: The Iodine 131 Experiment in Alaska*. Retrieved at: https://bioethicsarchive.georgetown.edu/achre/final/chap12_4.html

185 Ball, T.J. & Fisher, P.A. (2003). Tribal participatory research: mechanisms of a collaborative model. *American Journal of Community Psychology* 32(3-4), 207-216.

186 Laveaux, D., & Christopher, S. (2009). Contextualizing CBPR: key principles of CBPR meet the indigenous research context. *Pimatisiwin* 7(1), 1.

187 Sahota, P.C. (2010). Community-based participatory research in American Indian and Alaska Native communities. Retrieved from http://www.ncaipc.org/files/CBPR%20Paper%20FINAL.pdf.

188 National Indian Health Board. (2015b). Tribal epidemiology centers. Retrieved from http://www.nihb.org/tribal_resources/tribal_epidemiology.php.

189 Roberts, J., & Jones, J.D. (2004). Health disparities challenge public health among Native Americans. *Northwest Public Health* (Fall/Winter), 8-10.

190 Thomas, L.R., Donovan, D.M., Sigo, R.L., Austin, L., & Marlatt, G.A. (2009). The community pulling together: A tribal community-university partnership project to reduce substance abuse and promote good health in a reservation tribal community. *Journal of Ethnicity in Substance Abuse 8*(3), 283.

191 Pewewardy, C., & Hammer, P. C. (2003). Culturally Responsive Teaching for American Indian Students. ERIC Digest.

192 Hallett, D., Chandler, M.J., & Lalonde, C.E. (2007). Aboriginal language knowledge and youth suicide. *Cognitive Development 22,* 392-399.

193 Whitesell, N.R., Beals, J., BigCrow, C., Mitchell, C.M., & Novis, D.K. (2012). Epidemiology and etiology of substance use among American Indian and Alaska Natives: Risk, protection, and implications for prevention. *American Journal of Drug and Alcohol Abuse 38*(5), 376-382. doi: 10.3109/000952990.2012.694527.

194 Urban Indian Health Institute. (2012). *Addressing Depression Among American Indians and Alaska Natives: A Literature Review*. Seattle, WA: Urban Indian Health Institute.

195 Brown, B.G., Baldwin, J.A., & Walsh, M.L (2012). Putting tribal nations first: Historical trends, current needs, and future directions in substance use prevention for American Indian and Alaska youths. In C. Camp-Yeaky (Series Ed.) & S.R. Notaro (Vol. Ed.), *Advances in Education in Diverse Communities: Research, Policy and Praxis. 9*, pp. 3-47).

196 Brave Heart, M.Y.H. (1998). The return to the sacred path: Healing the historical trauma and historical unresolved grief response among the Lakota through a psychoeducational group intervention. *Smith College Studies in Social Work 68*(3), 288-305.

197 U.S. Department of Justice. Attorney General's Advisory Committee on American Indian/Alaska Native Children Exposed to Violence: Ending Violence so Children Can Thrive, November 2014.

198 U.S. Department of Justice. Attorney General's Advisory Committee on American Indian/Alaska Native Children Exposed to Violence: Ending Violence so Children Can Thrive, November 2014.

199 Walrath, C., Godoy Garraza, L., Reid, H., Goldston, D. B., McKeon, R., (2015). Impact of the Garrett Lee Smith Youth Suicide Prevention Program on Suicide Mortality. *American Journal of Public Health.* 105(5), pp. 986-993.

200 Godoy Garraza, L., Walrath, C., Goldston, D. B., Reid, H., McKeon, R., (2015). Impact of the Garrett Lee Smith Memorial Suicide Prevention Program on Suicide Attempts Among Youths. *JAMA Psychiatry*. 72(11): pp. 1143-9.

APPENDIXES

APPENDIX 1.
HIGHLIGHTS OF KEY NATIONAL TBHA INFORMATION GATHERING SESSIONS

EVENT	DATE	ACTIVITIES	APPROXIMATE PARTICIPATION
SAMHSA Tribal Technical Advisory Committee (TTAC)	2014 & 2015	Discussion on SAMHSA's internal Tribal Behavioral Health Agenda led to discussion on a national TBHA	8 tribal leaders (each year)
HHS Secretary's Tribal Advisory Committee	2014 & 2015	Discussion on accomplishments in health policy, services and resources and the need to continue momentum	14 tribal leaders 25 tribal representatives (each year)
White House Tribal Nations Conference	2014	First session on mental health was held	20 tribal leaders 20 audience members
HHS Regional Tribal Consultation – Nashville Area	2015	An overview of the concept and need for a Tribal Behavioral Health Agenda was presented	5 tribal leaders and 25 audience members
Tribal Self-governance Conference Session	2015	An overview of the concept and need for a Tribal Behavioral Health Agenda was presented with input sought	35 tribal leaders and members
National Tribal Advisory Committee on Behavioral Health	2015	An overview of the concept and need for a Tribal Behavioral Health Agenda was presented with input sought	7 Tribal representatives, 3 IHS Behavioral Health staff and 8 audience members
Department of Health and Human Services Annual Tribal Budget Consultation Session	2015	An overview of the concept and need for a Tribal Behavioral Health Agenda was presented with input sought	35 Tribal Leaders and 30 audience members
NIHB Board of Directors Meetings	March 4, 2015	An overview of the concept and need for a Tribal Behavioral Health Agenda was presented	10 Tribal leaders 15 audience members
	Sept. 20, 2015	A discussion was held on the content of the THBA and a resolution was passed in unanimous support of the TBHA	11 Tribal leaders 10 audience members
	Jan. 21, 2016	Board received an update on the development of the TBHA and a question and answer session was held on the content of the TBHA	10 Tribal leaders 20 audience members
NIHB National Tribal Public Health Summit	April 7, 2015	A special three hour session was held where facilitated small groups brainstormed outstanding needs and potential solutions to behavioral health challenges in Indian Country	80 Tribal members, public health practitioners, or stakeholders

EVENT	DATE	ACTIVITIES	APPROXIMATE PARTICIPATION
NIHB Annual Consumer Conference	Sept. 21, 2015	A special session was held where Tribal and federal leaders discussed the need for a TBHA, and written and verbal input was gathered from participants on the content and structure for the TBHA	120 Tribal members, Tribal leaders, health advocates, or stakeholders
	Sept. 24, 2015	A world Café style input session was facilitated to elicit feedback on content for the TBHA	200 Tribal members, Tribal leaders, health advocates, or stakeholders
National Council of Urban Indian Health 2015 Annual Leadership Conference	May 21, 2015	An overview of the TBHA was provided and discussion held to obtain responses for the six topical questions related to the development of the TBHA.	100 Tribal members, Urban Indian health leaders, health advocates, or stakeholders
SAMHSA Native American Youth Conference	Nov. 17-19, 2014	Youth developed a positive identity for change in Native American communities and shared challenges, provided recommendations, and asked questions of federal officials	150 youth 100 adults
National Congress of American Indians Mid-Year Meeting	June 30,2015	Presented overview of the TBHA and facilitated a question and answer session during the Health Sub-committee Meeting	35 tribal leaders, tribal members and health stakeholders
National Congress of American Indians Annual Convention and Marketplace	Oct. 19, 2015	Presented overview of the TBHA and facilitated a question and answer session during the Health Sub-committee Meeting	35 Tribal leaders, Tribal members, health advocates, or stakeholders
	Oct. 20, 2015	Sponsored a resolution for consideration and ultimately approval by Health Sub-committee and the Human Resources Committee	30 Tribal leaders, Tribal members, health advocates, or stakeholders
	Oct. 21, 2015	Hosted a two-hour discussion group around behavioral health priorities and recommend actions	80 Tribal leaders, Tribal members, health advocates, or stakeholders
Online Comment Period	Oct. 1 – Nov. 30, 2015	An open submission portal was created where anybody could submit open-ended comments on the TBHA or any thoughts related to behavioral health in Indian Country	15 online submissions
Federal Interagency Forum	Dec. 14, 2015	Federal agencies were invited to join in a discussion about what programs and efforts they currently operate that could align with TBHA priorities, and about how a TBHA could be utilized by their agencies	20 representatives from federal departments, agencies or offices 4 representatives from National Native American organizations
IHS Direct Service Tribes Quarterly Meeting	June 2, 2016	Presented overview of the TBHA and a question and answer session	10 tribal representatives 6 audience members

APPENDIX 2.
SELECTED LIST OF FEDERAL STRATEGIC PLANS AND DOCUMENTS — CORRELATIONS WITH THE NATIONAL TRIBAL BEHAVIOR HEALTH AGENDA

FEDERAL STRATEGIC PLANS/DOCUMENTS				RELATIONSHIP OF STRATEGIC PLAN TO TBHA											
Agency	Time	Name of Document	Selected Goal(s), Objectives, and Actions Period	Foundational Elements[1]					Cross-Cutting Considerations[2]						
				HT	SE	PR	HS	NA	Y	C	I	S	D	L
SAMHSA	2015-2018	Leading Change 2.0: Advancing the Behavioral Health of the Nation	Goal 1.1: Promote Emotional Health and wellness, prevent or delay the onset of and complications from substance abuse and mental illness, and identify and respond to emerging behavioral health issues Objective 1.1.1: Prevent Substance abuse and promote emotional health and well-being in states, territories, tribes, and communities across the nation			•								•
			Goal 1.2: Prevent and reduce underage drinking and young adult problem drinking Objective 1.2.3: Enhance cooperation and coordination among federal agencies and non-federal organizations to prevent and reduce underage drinking among youth and young adults			•			•					•
			Goal 1.3: Prevent and reduce attempted suicides and deaths by suicide among populations at high risk			•	•		•					•
			Objective 1.3.1: Promote suicide prevention as a core components of health care services, including integrated primary care services, consistent with Goal 8 of the National Strategy for Suicide Prevention						•		•			
			Objective1.3.2: Promote and implement effective clinical and professional practices and standards for assessing and treating those identified as high-risk for suicidal behaviors, especially among primary care, mental health, and substance abuse service providers			•	•							
			Objective 1.3.3: Promote rapid, continued, and skilled follow up with individuals who have attempted suicide or experienced a suicidal crisis			•	•							
			Objective 1.3.4: Increase public preparedness to address the warning signs for suicide and actions to take in response					•						•
			Goal 1.4: Prevent and reduce prescription drug and illicit opioid misuse and abuse Objective 1.4.3: Raise awareness and bring prescription drug misuse and abuse prevention activities and education to schools, communities, parents, prescribers, health care professionals, and other patients			•	•	•						•

1 Foundational elements: Historical and intergenerational trauma (HT); Socio-ecological Approach (SA); Prevention and Recovery (PR); Health Systems (HS); National awareness and visibility

2 Cross-cutting Considerations: Youth (Y); Culture (C); Identity (I); Individual self-sufficiency (S); Data (D); Tribal Leadership (L)

FEDERAL STRATEGIC PLANS/DOCUMENTS				RELATIONSHIP OF STRATEGIC PLAN TO TBHA										
Agency	Time	Name of Document	Selected Goal(s), Objectives, and Actions Period	Foundational Elements[1]					Cross-Cutting Considerations[2]					
				HT	SE	PR	HS	NA	Y	C	I	S	D	L
			Goal 2.1: Foster integration between behavioral health and health care, social support, and prevention systems Objective 2.1.2: Remove financial barriers and incentivize effective care coordination and integrated treatment delivery for people with mental illness and substance abuse conditions (for example: Schizophrenia, bi-polar disorder, and substance use disorder) through ongoing collaboration with federal partners and other stakeholders				•							•
			Goal 3.1: Implement and study a trauma-informed approach throughout health, behavioral health, and related systems Objective 3.1.1: Integrate an understanding of trauma and strategies for implementing a trauma-informed approach across SAMHSA, interested federal agencies, and other public service sectors	•			•							•
			Goal 4.1: Improve the physical and behavioral health of individuals with mental illness and/or substance use disorders and their families Objective 4.1.2: Promote recovery-oriented service systems that include coordinated clinical treatment and recovery support services			•	•							•
			Goal 6.1: Develop and disseminate workforce training and education tools and core competencies to address behavioral health issues Objective 6.1.4: In collaboration with HRSA, support investments in training the future behavioral health workforce to practice in integrated care settings and improve care for underserved populations				•							
			Goal 6.4: Influence and support funding for the behavioral health workforce Objective 6.4.1: Support the identification and analysis of pay incentives and barriers for behavioral health providers across settings				•						•	•
IHS	2011-2015	American Indian/ Alaska Native National Behavioral Health Strategic Plan	Strategic Direction I, Goal A. Mutual Tribal, Urban, and IHS planning and development of treatment services and programs. Action I.A.4: Develop recommendations and identify strategies to increase behavioral health data, generate aggregate data, and address data ownership issues. Utilize national, regional, and local data resources										•	
			Action I.A.7: Provide ongoing specialized prevention, intervention, and administrative training to better address new, emerging challenges in behavioral health and substance abuse clinical and program issues				•							
			Strategic Direction I, Goal B: Promoting national sharing of prevention, treatment, and education information Action I.B.4: Assess need for training and ongoing support of clinical supervisory positions in Tribal behavioral health programs and then collaborate with other Federal and Tribal resources, such as SAMHSA and research institutions, to promote train-the-trainer opportunities to enhance knowledge transfer and the application of agreed-upon behavioral health standards.				•							•

FEDERAL STRATEGIC PLANS/DOCUMENTS				RELATIONSHIP OF STRATEGIC PLAN TO TBHA											
Agency	Time	Name of Document	Selected Goal(s), Objectives, and Actions Period	Foundational Elements[1]					Cross-Cutting Considerations[2]						
				HT	SE	PR	HS	NA	Y	C	I	S	D	L
			Action I.B.5: Support local and regional efforts to utilize traditional AI/AN practitioners or practices within the service delivery framework for behavioral health.				•							•
			Strategic Direction II, Goal A: Creating a common awareness of and supporting behavioral changes towards wellness, sobriety, and community health Action II.A.2: Create a website portal to identify and disseminate best and promising practices in behavioral health					•						•
			Action II.A.3: Work with Tribal Technical Advisory Group to ensure that culture-based and tradition-based approaches are designated as evidence-based practices for purposes of funding and reimbursement.				•			•				•
			Action II.A.5: Support community-specific planning, readiness, and mobilization around the prevention of suicide, violence, and substance abuse by providing resources, collaborations, or connections to other Federal partners.			•								•
			Strategic Direction II, Goal B: Increasing resiliency and protective factors for AI/AN youth. Action II.B.5: Involve AI/AN youth in the identification and planning of strategies for the prevention of youth violence, substance abuse, and suicide.			•			•					
			Action II.B.7: Launch a system-wide collaboration between those working in child abuse neglect prevention and those working in behavioral health in order to coordinate services for the whole family.			•								•
			Strategic Direction III, Goal A: Encouraging the development and promotion of behavioral health standards and credentials. Action III.A.6: IHS, in consultation with Tribal and Urban leaders, will examine the creation, development, and deployment of a nationally funded crisis team to respond to behavioral health crises without depleting local resources. The guidelines for declaring a state of emergency and processes required to access emergency resources will be made available to all communities on an ongoing basis.				•							•
			Strategic Direction III, Goal B: Integrating behavioral health within thestructure of health services. Action III.B.4: Identify benchmarks and outcome measures to assess whether behavioral health is being integrated into health delivery systems. [Note: this action was shortened].				•						•	
			Action III.B.8: In partnership with local community members and persons served (including youth), conduct an education and awareness campaign to inform providers, persons served, and community members about behavioral health issues and resources.				•	•						•
			Action III.B.9: Through local leadership, integrate behavioral health within the larger aftercare and prevention framework of housing, law enforcement, education, and social services.		•		•							•

FEDERAL STRATEGIC PLANS/DOCUMENTS				RELATIONSHIP OF STRATEGIC PLAN TO TBHA										
Agency	Time	Name of Document	Selected Goal(s), Objectives, and Actions Period	Foundational Elements[1]					Cross-Cutting Considerations[2]					
				HT	SE	PR	HS	NA	Y	C	I	S	D	L
			Strategic Direction III, Goal C: Developing a skilled and culturally competent workforce to meet the demand for services. Action III.C.6: Seek additional funding for health career scholarships and web-based certification and licensure training specifically targeted at behavioral health professions, such as social work, psychology, counseling, etc. Change the priorities for health scholarships to emphasize behavioral health professionals training.				•							
			Action III.C.7: Implement a mentoring/internship/ preceptorship Initiative that provides recruitment of a new AI/AN workforce into behavioral health fields, by focusing resources and creating opportunities on a national and local level (e.g., National Behavioral Health Conference).				•							•
			Strategic Direction III, Goal D: Securing necessary reimbursement for behavioral health services. Action III.D.6: Seek support from CMS, IHS, and SAMHSA to ensure that cultural, traditional, or faith-based interventions and practices utilized in AI/AN behavioral health programs are considered as evidence-based programs or practices for purposes of reimbursement and provide training and technical assistance to secure evidence-based designation.				•			•				
			Strategic Direction III, Goal E: Sustaining interagency partnerships in order to support behavioral health. Action III.E.2: Work with tribal leaders to pursue increased multi- agency behavioral health funding and the development of a multi- agency behavioral health allocation process, including but not limited to HHS, HUD, DOI, ED, BIA, BIE, and other agencies.		•										•
			Action III.E.4: Modify the IHS Epidemiology cooperative agreements to		•								•	

FEDERAL STRATEGIC PLANS/DOCUMENTS				RELATIONSHIP OF STRATEGIC PLAN TO TBHA										
Agency	Time	Name of Document	Selected Goal(s), Objectives, and Actions Period	Foundational Elements[1]					Cross-Cutting Considerations[2]					
				HT	SE	PR	HS	NA	Y	C	I	S	D	L
			facilitate an inter-agency approach to the collection and use of aggregate behavioral health data in Tribal/Urban, regional, and national profiles.											
ACF	2015-2016	Administration for Children and Families Strategic Plan	Goal One: Promote economic, health, and social well-being for individuals, families, and communities 1.2.1 We will support families through successful implementation of healthy marriage and responsible fatherhood programs that encourage responsible parenting, foster economic stability, promote stable relationships and healthy marriages, take into consideration trauma- informed care, and work to create positive child outcomes.	•										
			1.3.3 We will incentivize the development of asset-building programs in underserved states and territories and among special populations, such as Native Americans, refugees, and survivors of human trafficking		•									
			Goal Two: Promote Healthy Development and School Readiness for Children, Especially Those in Low-Income Families 2.1.5 We will promote better policies and practices with regard to the social-emotional and behavioral development of children, including reducing preschool expulsion, promoting universal developmental screenings, strengthening family-program relationships, and implementing mental health consultations.		•		•							
			2.3.2 We will implement and evaluate the Tribal Early Learning Initiative, targeted to support tribes' efforts to effectively coordinate and leverage Child Care Development Fund, Early Head Start-Head Start, and Tribal Maternal, Infant, and Early Childhood Home Visiting program funding.		•									
			2.4.1 We will partner with federal agencies that support community and economic development, environmental protection, and native languages in order to leverage existing resources and programs to maximize ACF's investment in projects funded by the Administration for Native Americans. These partnerships will expand ANA's reach into communities and make other federal resources more accessible to ANA grantees.		•					•				•
			2.4.4 We will collaborate with federal partners to actively encourage states, tribes, and territories to promote interoperability, and improve access to integrated health care and human services.		•	•							•	•
			Goal Three: Promote Safety and Well-being of Children, Youth, and Families	•										

FEDERAL STRATEGIC PLANS/DOCUMENTS				RELATIONSHIP OF STRATEGIC PLAN TO TBHA											
Agency	Time	Name of Document	Selected Goal(s), Objectives, and Actions Period	Foundational Elements[1]					Cross-Cutting Considerations[2]						
				HT	SE	PR	HS	NA	Y	C	I	S	D	L
			3.1.1 We will promote the use of evidence-based and trauma-informed practices that effectively address the needs of children and families and encourage achievement of timely permanency for children in the child welfare system.											
			3.2.1 We will support youth and young adults in foster care in their transition to adulthood through technical assistance to state and tribal agencies and courts, and through policies, and programs that effectively address varying cultural/linguistic and other special needs, and the development of independence/self-sufficiency, including an emphasis on building financial capability, education and vocational training, and permanent connections with responsible, caring adults.		•				•	•	•			•
			3.3.4 We will establish common standards for ensuring that health and human service providers supported by ACF have the capacity to recognize the impact of domestic violence on the populations they serve, consider varying cultural/ linguistic and other special needs, and respond effectively and safely link program participants to domestic violence services as appropriate.			•		•		•				
			Goal Four: Support Underserved and Underrepresented Populations 4.1.6 We will promote and facilitate improved tribal/ state relations and policy at the regional and state levels to foster improved outcomes for Native American children, families, and communities.				•							•
			Goal Five: Upgrade the Capacity of the Administration for Children and Families to Make a Difference for Families and Children 5.2.10 We will work with the Native American Affairs Advisory Council to develop a data framework through which to collect, use, and share data more efficiently to inform decision making, educate stakeholders, increase the impact of ACF communications, and facilitate stronger partnerships to effectively address the demonstrated needs of Native American children, families, and communities.										•	•
OJJDP	Nov 2014	Attorney General's Advisory Committee on American Indian/ Alaska Native Children Exposed to Violence: Ending Violence so Children can Thrive	1.6 The legislative and executive branches of the federal government should encourage tribal-state collaborations to meet the needs of AI/AN children exposed to violence.											•
			1.7 The federal government should provide training for AI/AN Nations and for the federal agencies serving AI/AN communities on the needs of AI/AN children exposed to violence. Federal employees assigned to work on issues pertaining to AI/AN communities should be required to obtain training on tribal sovereignty, working with											

FEDERAL STRATEGIC PLANS/DOCUMENTS				RELATIONSHIP OF STRATEGIC PLAN TO TBHA										
Agency	Time	Name of Document	Selected Goal(s), Objectives, and Actions Period	Foundational Elements[1]					Cross-Cutting Considerations[2]					
				HT	SE	PR	HS	NA	Y	C	I	S	D	L
		This report was created as part of the Defending Childhood Initiative created by Attorney General Eric H. Holder, Jr. This initiative strives to harness resources from across the Department of Justice to: • Prevent Children's exposure to violence • Mitigate the negative impact of children's exposure to violence when it does occur; and • Develop knowledge and spread awareness about children's exposure to violence	tribal governments, and the impact of historical trauma and colonization on tribal Nations within the first sixty days of their job assignment.											
			2.4 The Indian Health Service (IHS) in the Department of Health and Human Services (HHS), state public health services, and other state and federal agencies that provide pre- or postnatal services should provide culturally appropriate education and skills training for parents, foster parents, and caregivers of AI/AN children. Agencies should work with tribes to culturally adapt proven therapeutic models for their unique tribal communities (e.g., adaptation of home visitation service to include local cultural beliefs and values).							•				
			2.6 The Secretary of Health and Human Services (HHS) should increase and support access to culturally appropriate behavioral health and substance abuse prevention and treatment services in all AI/AN communities, especially the use of traditional healers and helpers identified by tribal communities.			•				•				
			3.1.A The White House Native American Affairs Office, the U.S. Attorney General, the Secretaries of the Department of Interior (DOI) and Health and Human Services (HHS), and the heads of other agencies that provide funds that serve AI/AN children should annually consult with tribal governments to solicit recommendations on the mechanisms that would provide flexible funds for the assessment of local needs, and for the development and adaptation of promising practices that allow for the integration of the unique cultures and healing traditions of the local tribal community.	•						•				
			3.1.B The White House Native American Affairs Office and the U.S. Attorney General should work with the organizations that specialize in treatment and services for traumatized children, for example, National Child Traumatic Stress Network, to ensure that services for AI/AN children exposed to violence are trauma-informed.	•					•					
			3.1.C The White House Native American Affairs Office should coordinate the development and implementation of federal policy that mandates exposure to violence trauma screening and suicide screening be a part of services offered to AI/AN children during medical, juvenile justice, and/or social service intakes.		•		•		•					
			3.3 The White House Native American Affairs Office and responsible	•			•		•					

FEDERAL STRATEGIC PLANS/DOCUMENTS				RELATIONSHIP OF STRATEGIC PLAN TO TBHA										
Agency	Time	Name of Document	Selected Goal(s), Objectives, and Actions Period	Foundational Elements[1]					Cross-Cutting Considerations[2]					
				HT	SE	PR	HS	NA	Y	C	I	S	D	L
			federal agencies should provide AI/AN youth-serving organizations such as schools, Head Starts, daycares, foster care programs, and so forth with the resources needed to create and sustain safe places where AI/AN children exposed to violence can obtain services. Every youth-serving organization in tribal and urban Native communities should receive mandated trauma-informed training and have trauma-informed staff and consultants providing school-based trauma-informed treatment in bullying, suicide, and gang prevention/intervention											
			3.5 The White House Native American Affairs Office should work with Congress and executive branch agencies in consultation with tribes to develop, promote, and fund youth-based afterschool programs for AI/An youth. The programs must be culturally based and trauma-informed, must partner with parents/caregivers, and when necessary, provide referrals to trauma-informed behavioral health providers. Where appropriate, local capacity should also be expanded through partnerships with America's volunteer organizations, for example, Americorps.		•		•		•	•				
			3.6 The White House Native American Affairs Office and the Secretary of Health and Human Services (HHS) should develop and implement a plan to expand access to Indian Health Service (IHS), tribal, and urban Indian centers to provide behavioral health services to AI/AN children in schools This should include the deployment of behavioral health services providers to serve students in the school setting.				•		•					
			NOTE: Chapter 3 following 3.6 goes on to explain that: "Federal agencies should work with public schools and Bureau of Indian Education (BIE)-funded schools to ensure that services are offered, preferably in the schools, to students attending BIE-funded schools. School-based services increase the availability and utilization of services and will increase safety in schools."											
BIE	July 2014	Findings and Recommendations Prepared by the Bureau of Indian Education Study Group Submitted to the Secretaries of the	Reform Area 4: Comprehensive Supports through Partnerships In September 2013, Secretary of the Interior Sally Jewell and Secretary of Education Arne Duncan appointed the American Indian Education Study Group to diagnose the causes of too common academic failure in BIE- funded schools. The Study Group, based largely on written comments and feedback received during tribal consultations, recommends that the	•	•										

FEDERAL STRATEGIC PLANS/DOCUMENTS				RELATIONSHIP OF STRATEGIC PLAN TO TBHA											
Agency	Time	Name of Document	Selected Goal(s), Objectives, and Actions Period	Foundational Elements[1]					Cross-Cutting Considerations[2]					
				HT	SE	PR	HS	NA	Y	C	I	S	D	L
		Departments of the Interior and Education The Study Group's findings focus on five areas of reform: • Highly Effective Teachers and Principals • Agile Organizational Environment • Promote Educational Self- Determination for Tribal Nations • Comprehensive Supports through Partnerships • Budget that Supports Capacity- Building Mission	BIE focus on fostering five areas of reform. Issues raised related to partnerships and that are pertinent to the TBHA include: traumas faced by students and families, impact of trauma on academic performance, depression, substance abuse, poor health outcomes, high unemployment, rampant crime, support so that students come to class ready to learn, leveraging local and national expertise, and innovative partnerships to address social problems. The Study Group recommended that BIE's approach cut across all Federal agencies and their community-based programs that serve tribal communities to eliminate redundancy, disconnection, and waste of federal resources.											
			Select Partnership Recommendations:											
			• Coordinate with other Federal agencies so that community-based tribal grants help provide wraparound services to students attending BIE-funded schools.						•					
			• Work with Indian Health Service (IHS) to increase and institutionalize the practice of providing school-based services to ensure that students are ready to learn and can focus (e.g., provision of immunizations in time for start of school and counseling services)				•							

APPENDIX 3:
TRIBAL RESOLUTIONS SUPPORTING THE NATIONAL TRIBAL BEHAVIORAL HEALTH AGENDA

National IndianHealth Board

National Indian Health Board

National Indian Health Board
Resolution 15 - 01

Declaration for Support of a Tribal Behavioral Health Agenda

WHEREAS, the National Indian Health Board (NIHB), established in 1972, serves all federally recognized American Indian and Alaska Native (AI/AN) Tribal governments by advocating for the improvement of health care delivery to AI/ANs, as well as upholding the federal government's trust responsibility to AI/AN Tribal governments; and

WHEREAS, the NIHB has a strong history of advancing the emotional, spiritual, and mental well-being of American Indian and Alaska Native people through the support of regulatory and Congressional action, advocacy for increased funding for behavioral health in Indian Country, creation of national venues to discuss behavioral health issues (such as suicide and substance use), and creation of educational and programmatic materials for Tribal public health professionals; and

WHEREAS, the high rates of behavioral health challenges among American Indian and Alaska Native people create an urgency for Tribes, federal agencies, and other stakeholders to partner in a manner that seeks to improve the health of all American Indians and Alaska Natives; and

WHEREAS, there is currently no one single, national document that elevates the importance of behavioral health for AI/AN people, identifies the collective priorities of Tribal communities related to behavioral health, and guides the development of/or incorporation of behavioral health-related actions intended to improve the well-being of American Indian and Alaska Native youth, families, and communities; and

WHEREAS, in order to create a blueprint for effectively addressing behavioral health, Tribal leaders, Tribal members and stakeholders from diverse sectors need to be meaningfully engaged so as to garner input and feedback on behavioral health priorities, goals, and recommendations; and

WHEREAS, the Substance Abuse and Mental Health Services Administration (SAMHSA) is the federal agency that has allocated staff and resources to serve as the federal lead in the development and creation of a blueprint for advancing behavioral health in Indian Country; and

WHEREAS, SAMHSA and NIHB have forged a partnership to reach into Indian Country and engage Tribal leaders, Tribal members, community stakeholders, youth, partner organizations, and other federal agencies to create a Tribal Behavioral Health Agenda to serve as a single, national blueprint for shaping collaborations, prioritizing issues, elevating awareness, and establishing realistic, actionable items; and

NOW THEREFORE BE IT RESOLVED, that the National Indian Health Board will work to create a Tribal Behavioral Health Agenda to advance Tribal and federal action to improve the emotional, spiritual and mental health of American Indian and Alaska Native people; and

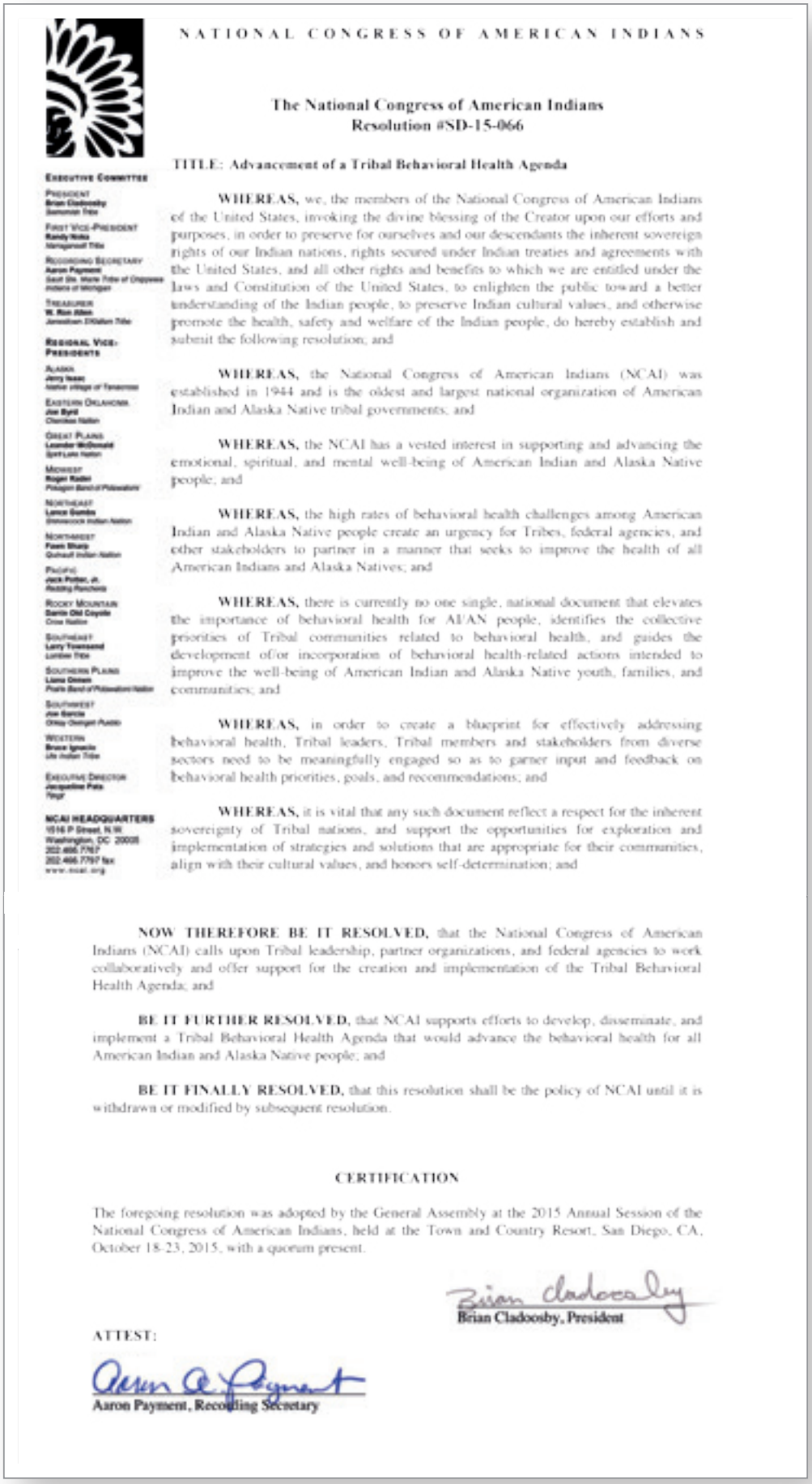
NOW THEREFORE BE IT RESOLVED, the National Indian Health Board calls upon Tribal leadership, partner organizations, and federal agencies to work collaboratively and offer support for the creation and implementation of the Tribal Behavioral Health Agenda.

BE IT FINALLY RESOLVED, that National Indian Health Board supports efforts to develop, disseminate, and implement a Tribal Behavioral Health Agenda for all of Indian Country.

CERTIFICATION

The foregoing resolution was adopted by the Board, with quorum present, on the 20th day of September, 2015.

Leader Secatero
Chairperson



NATIONAL CONGRESS OF AMERICAN INDIANS

The National Congress of American Indians
Resolution #SD-15-066

TITLE: **Advancement of a Tribal Behavioral Health Agenda**

WHEREAS, we, the members of the National Congress of American Indians of the United States, invoking the divine blessing of the Creator upon our efforts and purposes, in order to preserve for ourselves and our descendants the inherent sovereign rights of our Indian nations, rights secured under Indian treaties and agreements with the United States, and all other rights and benefits to which we are entitled under the laws and Constitution of the United States, to enlighten the public toward a better understanding of the Indian people, to preserve Indian cultural values, and otherwise promote the health, safety and welfare of the Indian people, do hereby establish and submit the following resolution; and

WHEREAS, the National Congress of American Indians (NCAI) was established in 1944 and is the oldest and largest national organization of American Indian and Alaska Native tribal governments; and

WHEREAS, the NCAI has a vested interest in supporting and advancing the emotional, spiritual, and mental well-being of American Indian and Alaska Native people; and

WHEREAS, the high rates of behavioral health challenges among American Indian and Alaska Native people create an urgency for Tribes, federal agencies, and other stakeholders to partner in a manner that seeks to improve the health of all American Indians and Alaska Natives; and

WHEREAS, there is currently no one single, national document that elevates the importance of behavioral health for AI/AN people, identifies the collective priorities of Tribal communities related to behavioral health, and guides the development of/or incorporation of behavioral health-related actions intended to improve the well-being of American Indian and Alaska Native youth, families, and communities; and

WHEREAS, in order to create a blueprint for effectively addressing behavioral health, Tribal leaders, Tribal members and stakeholders from diverse sectors need to be meaningfully engaged so as to garner input and feedback on behavioral health priorities, goals, and recommendations; and

WHEREAS, it is vital that any such document reflect a respect for the inherent sovereignty of Tribal nations, and support the opportunities for exploration and implementation of strategies and solutions that are appropriate for their communities, align with their cultural values, and honors self-determination; and

NOW THEREFORE BE IT RESOLVED, that the National Congress of American Indians (NCAI) calls upon Tribal leadership, partner organizations, and federal agencies to work collaboratively and offer support for the creation and implementation of the Tribal Behavioral Health Agenda; and

BE IT FURTHER RESOLVED, that NCAI supports efforts to develop, disseminate, and implement a Tribal Behavioral Health Agenda that would advance the behavioral health for all American Indian and Alaska Native people; and

BE IT FINALLY RESOLVED, that this resolution shall be the policy of NCAI until it is withdrawn or modified by subsequent resolution.

CERTIFICATION

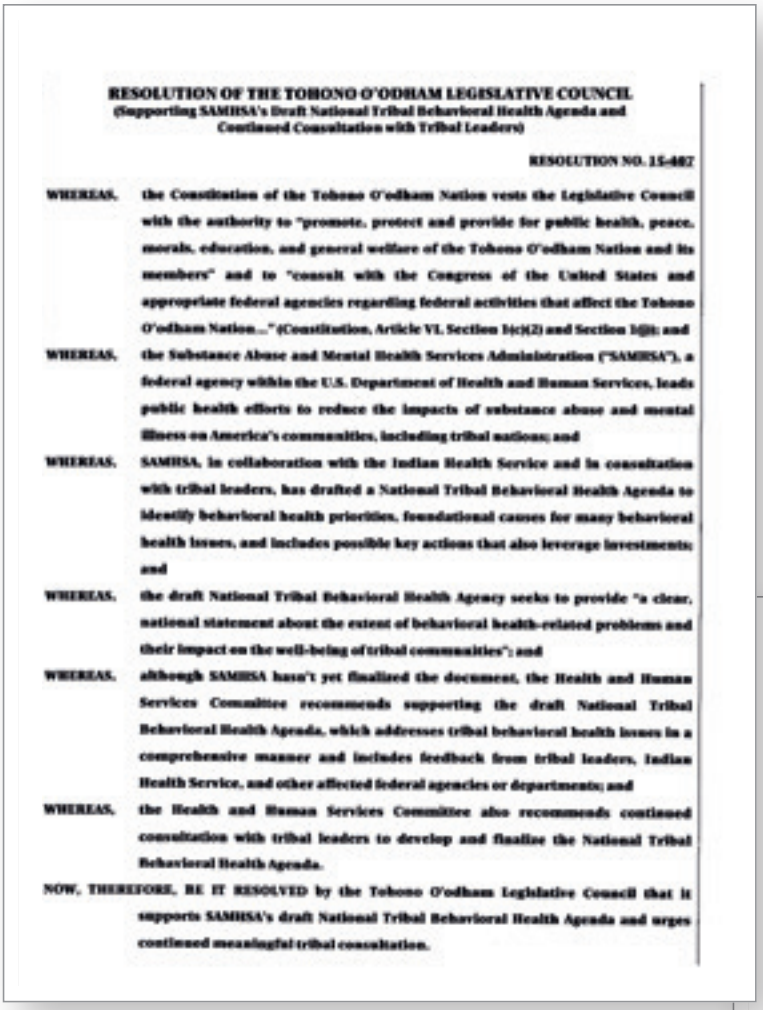
The foregoing resolution was adopted by the General Assembly at the 2015 Annual Session of the National Congress of American Indians, held at the Town and Country Resort, San Diego, CA, October 18-23, 2015, with a quorum present.

Brian Cladoosby, President

ATTEST:

Aaron Payment, Recording Secretary

Tohono O'odham Nation



RESOLUTION OF THE TOHONO O'ODHAM LEGISLATIVE COUNCIL
(Supporting SAMHSA's Draft National Tribal Behavioral Health Agenda and Continued Consultation with Tribal Leaders)

RESOLUTION NO. 15-407

WHEREAS, the Constitution of the Tohono O'odham Nation vests the Legislative Council with the authority to "promote, protect and provide for public health, peace, morals, education, and general welfare of the Tohono O'odham Nation and its members" and to "consult with the Congress of the United States and appropriate federal agencies regarding federal activities that affect the Tohono O'odham Nation..." (Constitution, Article VI, Section 1(c)(2) and Section 1(jj); and

WHEREAS, the Substance Abuse and Mental Health Services Administration ("SAMHSA"), a federal agency within the U.S. Department of Health and Human Services, leads public health efforts to reduce the impacts of substance abuse and mental illness on America's communities, including tribal nations; and

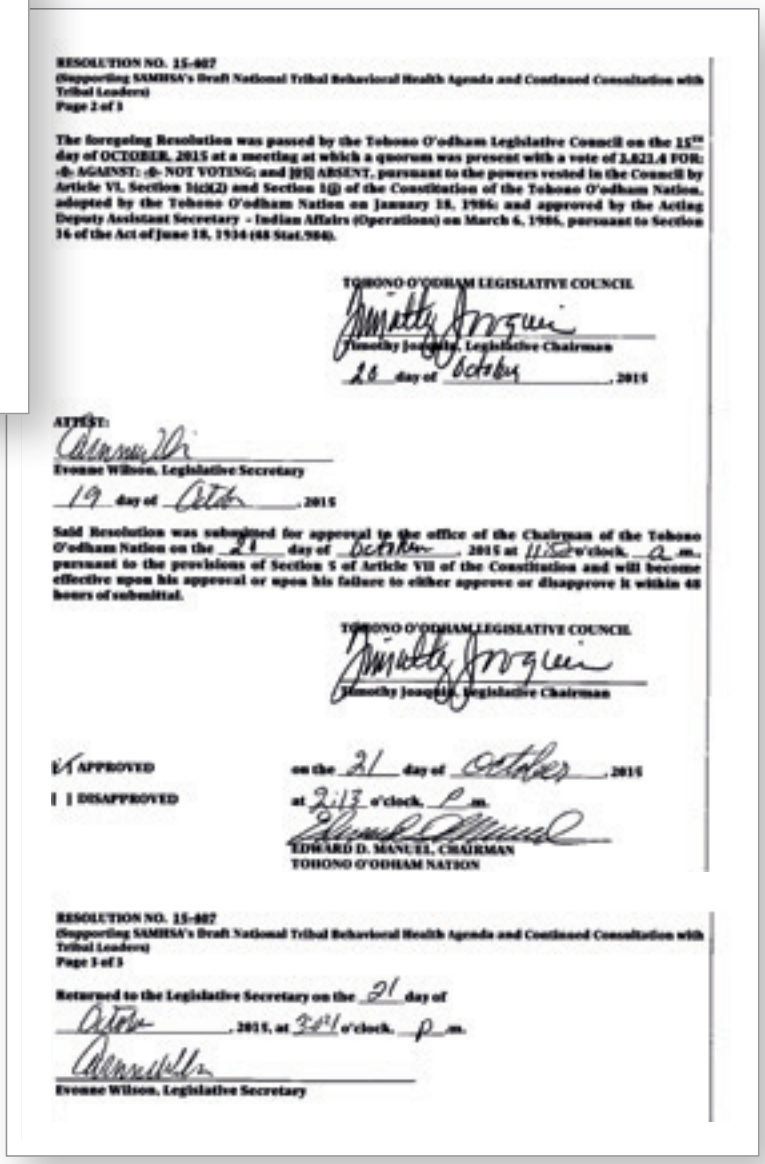
WHEREAS, SAMHSA, in collaboration with the Indian Health Service and in consultation with tribal leaders, has drafted a National Tribal Behavioral Health Agenda to identify behavioral health priorities, foundational causes for many behavioral health issues, and includes possible key actions that also leverage investments; and

WHEREAS, the draft National Tribal Behavioral Health Agency seeks to provide "a clear, national statement about the extent of behavioral health-related problems and their impact on the well-being of tribal communities"; and

WHEREAS, although SAMHSA hasn't yet finalized the document, the Health and Human Services Committee recommends supporting the draft National Tribal Behavioral Health Agenda, which addresses tribal behavioral health issues in a comprehensive manner and includes feedback from tribal leaders, Indian Health Service, and other affected federal agencies or departments; and

WHEREAS, the Health and Human Services Committee also recommends continued consultation with tribal leaders to develop and finalize the National Tribal Behavioral Health Agenda.

NOW, THEREFORE, BE IT RESOLVED by the Tohono O'odham Legislative Council that it supports SAMHSA's draft National Tribal Behavioral Health Agenda and urges continued meaningful tribal consultation.



RESOLUTION NO. 15-407
(Supporting SAMHSA's Draft National Tribal Behavioral Health Agenda and Continued Consultation with Tribal Leaders)
Page 2 of 3

The foregoing Resolution was passed by the Tohono O'odham Legislative Council on the 15TH day of OCTOBER, 2015 at a meeting at which a quorum was present with a vote of 3,823.4 FOR; -0- AGAINST; -0- NOT VOTING; and 10 ABSENT, pursuant to the powers vested in the Council by Article VI, Section 1(c)(2) and Section 1(jj) of the Constitution of the Tohono O'odham Nation, adopted by the Tohono O'odham Nation on January 18, 1986; and approved by the Acting Deputy Assistant Secretary - Indian Affairs (Operations) on March 6, 1986, pursuant to Section 16 of the Act of June 18, 1934 (48 Stat.984).

TOHONO O'ODHAM LEGISLATIVE COUNCIL
Timothy Joaquin, Legislative Chairman
16 day of October, 2015

ATTEST:
Yvonne Wilson, Legislative Secretary
19 day of Oct, 2015

Said Resolution was submitted for approval to the office of the Chairman of the Tohono O'odham Nation on the 21 day of October, 2015 at 11:52 o'clock, a m., pursuant to the provisions of Section 5 of Article VII of the Constitution and will become effective upon his approval or upon his failure to either approve or disapprove it within 48 hours of submittal.

TOHONO O'ODHAM LEGISLATIVE COUNCIL
Timothy Joaquin, Legislative Chairman

[X] APPROVED
[ ] DISAPPROVED

on the 21 day of October, 2015
at 2:13 o'clock, P m.
EDWARD D. MANUEL, CHAIRMAN
TOHONO O'ODHAM NATION

RESOLUTION NO. 15-407
(Supporting SAMHSA's Draft National Tribal Behavioral Health Agenda and Continued Consultation with Tribal Leaders)
Page 3 of 3

Returned to the Legislative Secretary on the 21 day of October, 2015, at 3:41 o'clock, p m.
Yvonne Wilson, Legislative Secretary

Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

INDIAN HEALTH SERVICE
PHS • 1955

National Indian
Health Board